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# children

Comprehensive Health Care

Children's Rights—
in the Courts
in Medical Research

Involving Parents in Day Care

VOLUME 16 • NUMBER 4 • JULY–AUGUST 1969

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# children

AN INTERDISCIPLINARY JOURNAL FOR THE PROFESSIONS SERVING CHILDREN

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Pediatrician, mother, and child participating in a project to provide comprehensive health care for preschool and schoolage children in San Francisco, Calif. This is one of the 58 projects supported by the Children's Bureau in low-income areas throughout the country that are finding new ways to provide continuous, preventive, and remedial health care to children. (See pp. 130–137.)

# children


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"But what can we do to gain their trust?"

A young pediatrician asked the question of a community aide during a team conference in his office in an inner-city neighborhood pediatric clinic, converted from a two-story family home. The pediatrician was concerned about the distrust he sensed in the mothers who brought their children to the clinic for care. He waited attentively for the answer as did the other members of the team present—a psychiatrist, a clinic nurse, a public health nurse, a social worker, and a licensed practical nurse.

"Smile a little, and don't be in such a hurry," answered the aide, herself a resident of the black ghetto neighborhood being served. "Look at us as though we were people." She paused, then added, "But you do that here in the children's clinic. It's nicer here than in most clinics."

But the young doctor persisted.

"I can feel my patients' wariness. They sit across the room when they first come in instead of up by my desk. Not until after the second or third visit do they relax. What should we do? Make house calls?"

"No!" replied the aide emphatically. "They'd suspect you were trying to find out something. Nobody should visit the homes but the people who live in the neighborhood."

This exchange took place last summer in Denver, Colo. In its setting, the different kinds of staff members present, the search for a way to better rapport between the server and the served, and the professional's request for guidance from a nonprofessional team member, it illustrates something of the revolutionary approach to the provision of health care for

# promoting CHILD HEALTH through COMPREHENSIVE CARE

KATHRYN CLOSE

children being made in many areas of poverty today. The neighborhood clinic in which it took place is part of Denver's project for the comprehensive health care of preschool and schoolage children, one of 58 such projects supported by the Federal Government through the Children's Bureau in low-income areas throughout the country. Multidisciplinary team discussions, including both professional and nonprofessional team members, are common occurrences in such projects. And the invisible barrier between the professional person and clinic patient, sensed by the young doctor, is a problem bequeathed today's service efforts by the indifferent, disconnected services so often encountered by poor people in the past.

The comprehensive health care projects for children, usually called children and youth projects, represent attempts to get away from the fragmented service patterns of the past and to find ways of providing health care geared to the needs of children as whole developing human beings. Established under the 1965 amendments to the Social Security Act,[1] they are based on the assumption—spelled out in the law—that attention to the whole child requires comprehensiveness, accessibility, high quality, coordination, and continuity in both preventive and treatment services. Interpreting comprehensiveness broadly, they are not only providing children with preventive and therapeutic medical and dental care, but are also attempting to deal with the many aspects of the environment that affect a child's health, whether in the home, school, or community—helping mothers get a greater nutritional leverage for their families out of scant food budgets, working with them on the emotional problems that block good parent-child relationships, conducting group discussions for teenage mothers, putting pressure on landlords to repair defective plumbing or heating equipment, and even, at least in one project, helping the people of the neighborhood organize an egg-buying cooperative.

An observer has predicted that the children and youth projects will have an important effect on the Nation's health.[2] The reason: the children and youth projects are bringing about changes in methods of providing health care among long-existing services, welding service fragments into a meaningful whole, and establishing new services to fill important gaps. The legal and administrative requirements are flexible enough to allow for experimentation in new ways of reaching children needing attention, of using various kinds of staff members to the patient's best advantage, and of effecting salutary changes in communities as well as in individual families and children.

As demonstrations of methods of health care, the children and youth projects are confined to defined geographic areas predominantly inhabited by the poor—usually several census tracts within the center of a large city, but in a few instances, whole counties or even a combination of counties. While the projects provide medical treatment and hospitalization only to children whose families are considered medically indigent, their preventive services are available to all children living in the target areas.

Under the law, the Children's Bureau may make grants for operating such projects up to June 30, 1972, to State or local health departments, State crippled

children's agencies, schools of medicine, or teaching hospitals affiliated with such schools, the grantee being responsible for 25 percent of the cost. The appropriation for the 58 projects in operation in fiscal year 1969 was $39 million.

## Common characteristics

Although varying in administrative structure and emphasis, the projects share many common characteristics. All but a few are directed by a pediatrician with the assistance of a core multidisciplinary team, usually composed of an administrative officer, a public health nurse, a social worker, a dentist, and a nutritionist, with consultation available from other specialists, such as psychologists, psychiatrists, physical therapists, occupational therapists, and hearing and speech specialists. Through similar multidisciplinary teams—augmented by audiologists, technicians, and various types of nonprofessional aides—they provide preventive, diagnostic, and treatment services in clinics near the children's homes, backed up by the specialty services and facilities of modern hospitals. They reach out to find unserved children by working closely with the schools and other community agencies and follow up on broken appointments through visits to the children's homes. Looking on each child they serve as a whole human being, they attend to the many intermingling aspects of his physical, emotional, and mental condition, providing immunizations, health education, nutritional advice, and parental counseling to keep him well, treating his illnesses, and correcting his defects insofar as possible.

While the projects are pediatric services and so provide medical care only to children and adolescents, they are, for the most part, family-centered pediatric programs. For example, when a child is brought into a clinic for the first time—often for treatment of transitory illness or because the mother is worried about his failure to gain weight—subsequent appointments are made for complete health assessments not only for him but also for all the other children in the family. If the appointments are not kept, a followup visit may be made to the home to find out why and to learn as much as possible about the other children. In many clinics children of the same family are examined by the same doctor. The clinics usually keep family records and arrange for all the children in the family to come in on the same day to save the mother's time. Sometimes the really serious problems in the family turn out to be those of children the mother left at home on her first visit.

Although the children and youth projects do not provide medical care to adults—except in a few places where they are integrated with clinics sponsored by the Office of Economic Opportunity—they focus a great deal of their attention on mothers in an effort to help them strengthen family life and so provide a nurturing environment for their children. They provide or arrange with another agency to provide the service of a homemaker when she is ill, social casework to increase her ability to tackle her family problems, nutritional education and dietary counseling in line with her family's likes and dislikes; and help in applying for public assistance, finding suitable housing in an emergency, or getting medical attention for herself. They also help fathers in similar ways.

For example, a 10-year-old girl who became ill in school with a severe headache and vomiting was taken to a neighborhood clinic of a children and youth project. After examining her the pediatrician asked the nutritionist to make an immediate home visit. The nutritionist learned that one head of cabbage had served as the entire dinner the previous day for the mother, father, and two children, and that the family's only resources were $5 and some flour and a little bit of milk. The father, a day laborer, had been out of work for 2 weeks because of illness, but was ready to go back. After taking the mother shopping to stretch the $5 as far nutritionally as possible, the nutritionist taught the mother and daughter how to bake bread. Her friendliness encouraged the parents to take the other child, a little boy, to the clinic where he received a health assessment and badly needed dental care, and where the social worker talked with the parents, helping them to plan ahead to meet future crises and to get enrolled in Medicaid to take care of their own medical needs.

## Variations

The 58 projects present a variety of patterns for reaching and serving children and their parents. Each one is to a large degree molded by the characteristics, resources, and needs of the community it serves and, also, to some extent, by the special interests and proclivities of its operating agency, its director, and its staff members.

Thus some projects try to provide some service to every child in the target area and so spend a great deal of effort on casefinding—visiting schools, churches, and other neighborhood organizations and

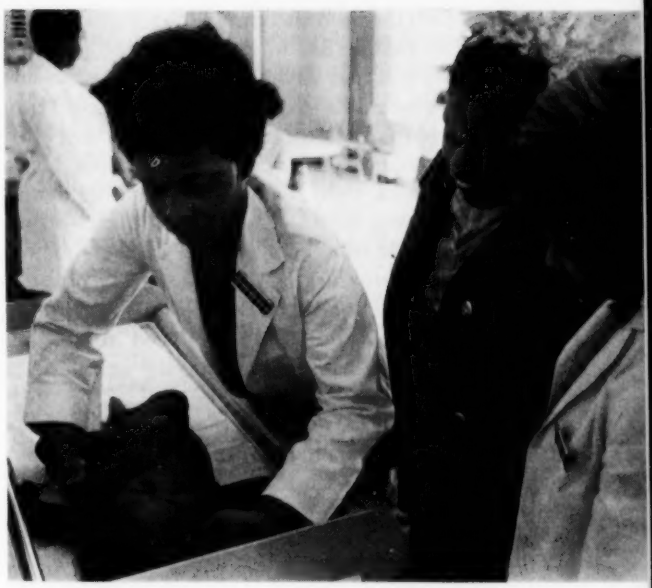
even sending staff members from door to door in the neighborhood to acquaint people with the services available. Some, in areas where school health services are minimal or lacking, provide visual and auditory screening and even physical examinations to schools, as well as to Head Start programs, in their target neighborhoods. Other projects are concentrating on giving more intensive attention to the families registered with them.

Some projects have set up special clinics for adolescents; others are concentrating their attention on the care of children under 6. A few, impressed by the evidence they see of a tie-in between a child's school experience and his emotional state, have assumed responsibility for helping children with school problems: one provides a "learning clinic" staffed by two psychologists; another, a reading specialist; still another, group therapy sessions for boys suspended from school because of behavior problems.

One project, in a city where the inside walls of many old tenements have undercoatings of lead-based paint—picked off and eaten by many small children—operates a special casefinding and treatment program for children with lead poisoning. Another, in an area where defects in plumbing and heating equipment are common, includes ecologists on its staff to work with families and local authorities to eliminate such hazards to children's health and safety. The latter project also has a staff of home aides, working under a home economist, to help mothers with household management and nutrition. A project in an area inhabited largely by persons of Mexican heritage has hired a social anthropologist to increase the staff's understanding of the strength and meaning of the ethnic customs and study reactions of the families being served; another, in an inner-city area where Puerto Ricans predominate, has instituted compulsory Spanish lessons for the non-Spanish-speaking members of its staff.

A few projects have added occupational therapists to their staffs to observe the motor coordination of children in the clinic's play area, to report noticeable developmental lags to physicians, and to show mothers how to devise play programs that will stimulate their children appropriately. One project has established a developmental evaluation center for the study, treatment, and followup of children suspected of deviating from the norm in mental or physical development.

Five or six projects have put physical therapists on their staffs to work with handicapped children. The other projects usually purchase physical therapy, when needed, from their back-up hospitals or elsewhere or secure this service from the States' crippled children's programs.



Mother and clinical nurse watch a health aide weigh a baby in the pediatric clinic of the comprehensive health care project for children at the Mount Zion Hospital, San Francisco.

## Dental care

Dental care is required by law of every project. The methods of providing such care vary as does the scope of the care. Many projects have equipped their neighborhood clinics with dental chairs and staffed them with full-time or part-time dentists, dental hygienists, and dental aides.

In Kansas City, Kans., for example, every child registered with the project's neighborhood center is given a complete dental examination with a full mouth X-ray, his teeth are cleaned, his cavities are filled, and recall appointments are made for him at regular intervals. In this center eight part-time dentists rotate in providing treatment; a dental hygienist takes X-rays, cleans teeth, applies topical fluoride and instructs children, in the clinic and in the public and parochial schools in the area, on how to take good care of their teeth; and two dental assistants rotate in helping the dentist and serving as receptionist.

So great is the backlog of dental need among children in the project areas that few projects have been

able to meet all the need encountered. One project, for example, has found that 67 percent of the children registered with it had never been to a dentist. Some projects have been able to offer continuing dental care to selected groups of children only, serving other children only on an emergency basis. For example, in the project at Aurora, Colo., complete continuing dental care with followup is offered only to children who are in the first grade of school at time of registration. Other projects provide dental assessment, prophylaxis, treatment of cavities, and followup to all project-registered children but have been unable to provide orthodontia or dental surgery except in a few cases.

A few projects have enlarged the supervisory staffs of local dental schools and arranged for project patients to be served by the students, interns, and residents. Others have arranged with local dental societies to provide dental care to project patients on a fee-for-service basis. Still others rely on volunteer dentists to augment the services of a small dental staff.

## Some plusses

"We do everything a pediatrician normally does in his office—plus," said a physician recently in describing the operations of a neighborhood clinic in a children and youth project. By "everything" he meant that each child coming to the clinic was immunized against communicable diseases and given a complete health assessment, with urinalysis and blood tests and screening tests for tuberculosis and hearing and visual defects; that sick children were treated at the clinic or hospitalized, if necessary; and that arrangements were made with appropriate specialists for further diagnosis and remedial treatment of children with obvious or suspected defects. By the "plus" he was referring to the services of those nonmedical members of the clinic's staff—the public health nurse, the social worker, the nutritionist, and community aides—who look into the child's daily life and try to deal with whatever impediments may be blocking his natural tendency to grow into a healthy human being, whether these are in his mother's ability to understand or follow the physician's directions, the relationships in his family, the condition of his home, his behavior and performance at school, or what he is getting to eat.

The public health nurses visit the homes of new patients to assess health conditions, follow up on how clinic recommendations are being carried out, and counsel the family on general health practices. They also do individual teaching in the clinics, conduct group discussions in child care for new mothers, especially teenage mothers, and work with nutritionists on self-improvement programs for obese girls. In some projects they also provide health services to the schools in the target neighborhoods.

In most projects, a public health nurse serves as a nurse coordinator to assure continuity of care by providing a liaison between the children and youth clinics, the home, the inpatient department of the back-up hospital, and the hospital's emergency service, where the patients go for treatment of acute illnesses in the night and during weekends when the clinics are closed.

Working different ways in different projects, the nutritionists teach parents the importance of food of the right kind and ways of stretching the family food dollar. They evaluate children's diets and food habits and counsel parents and older children in relation to both normal eating patterns and therapeutic diets for children with nutritional deficiencies, metabolic diseases, or other disorders. They work in the clinics with groups of parents and teenagers as well as with individuals and provide consultation to other staff members such as the nurses and social workers. They reach out to the community with nutrition education, working through the schools and community groups. They also work with individual families in the community, often with the help of dietitians, home economists, and staff aides to teach parents how to shop wisely, obtain food stamps or donated foods when needed and available, prepare and use donated foods, and improve methods of home management.

Like the nutritionists, the social workers function differently in different projects. In some of the smaller projects they try to see every child and mother in a kind of screening interview to determine whether the family needs help with problems. In larger projects they usually see only selected types of patients, for example, teenage unmarried mothers, children referred by the schools because of behavior problems, and mothers facing a family crisis, such as eviction or the breakup of a home.

Some social workers provide intensive casework in selected cases to help parents find the inner strength to cope with their family problems themselves. Others see their service as crisis oriented—being available to help parents and children deal with emergencies whenever they occur.

So many medical problems seen in the pediatric clinics derive from community problems—bacterial

dysentery, rat bites, lead poisoning, to name a few—that some project social workers are beginning to shift their emphasis from casework treatment to prevention by focusing attention on the need for community change.

In Washington, D.C., for example, a project social worker has organized a parents' group that has conducted a neighborhood cleanup campaign and prevailed upon the city authorities to institute a rat control program. Similarly, a social worker in a New York City project has helped organize the tenants of a public housing project to get a family planning service established in the neighborhood.

## Community links

The projects lean heavily on nonprofessional aides who reside in the target neighborhoods to break through the cultural barriers between their highly professional staff members and the depressed populations they serve. They employ neighborhood people as social work assistants, community aides, family health aides, nurse's aides, nutritionist's aides, home aides, dental aides, laboratory aides, receptionists, clerical workers, and in a host of other capacities. Some of these aides have been trained on the job, and some in special programs sponsored by community agencies or local community colleges.

Altogether the 58 projects have more than 750 neighborhood aides on their staffs. These aides have become the projects' true link to the community. Being a part of the target neighborhoods, they know what it is like to live in a poverty-stricken community and what prevents families from providing children with the conditions conducive to health. Because they speak the local language—figuratively and literally—they often have a better entree to a family's home or confidence than the somewhat exalted professional person and a more realistic understanding of how the family might react to clinic recommendations.

A nutritionist's aide, for example, when asked to comment on a doctor's instructions on baby feeding for new mothers immediately objected to the statement, "Discard any formula left in the bottle after the baby has finished feeding." Said she: "These mothers will be shocked at the idea of throwing food away. Better say: 'Don't give any leftover formula to the baby again.' Maybe the mother will drink it herself."

Another aide warned against the use of the word "carbohydrate" in connection with the baby's food, saying she had looked the word up in the dictionary and found it defined as "starch" or "sugar." Pointing out that many women from the South eat laundry starch, particularly during pregnancy, she asked, "You don't want the mothers to put starch in the baby's formula, do you?"

Still another commented: "Mothers don't know what you mean by *scald*. Say *boil*."

In many projects the community aides are recognized as important members of the service team. They follow up on broken appointments, acquaint families with community resources, learn about conditions in the home, and keep the project informed about what is going on in the neighborhood. In some projects, as at the Mount Zion Hospital in San Francisco, they attend all team conferences with the staff members, who pay careful attention to their reports: a mother "talks about illness and death all the time" but pays no attention to her adolescent daughter's complaints of headaches and heart pains; an unmarried expectant teenage mother wants to keep her baby but refuses to register at a prenatal clinic "because she wants to be considered as a person, not a case"; a young mother used up a month's supply of readymade formula in a week because "she fed it to all four of her children when she ran out of

**A speech therapist working with a child in a comprehensive care clinic of the Children's Hospital in Washington, D.C.**

food"; an irate mother complained to the school about a teacher's treatment of her child and "that just made things worse."

The community aides also perform an important function in making the project's services known to the community and in finding families that need the project's help.

In Denver, for example, a community aide learned of an 18-month-old child who still could not walk. She helped the fearful, distraught mother, who could not speak English, take the child to a clinic of the children and youth project. When a thorough physical and medical examination showed that there were no organic difficulties, the clinic's public health nurse went into the home with a Spanish-speaking practical nurse. The home situation proved to be rife with tensions stemming from the autocratic behavior of the father. After a conference between the public health nurse, the social worker, and the nutritionist, arrangements were made for the practical nurse to visit the home regularly to teach the mother English while helping her to learn how to give the baby appropriate care and stimulation, to feed her children nutritiously, and to find ways of breaking down the father's resistance to getting the other children to the clinic for care.

## Revolutionary methods

The projects vary in complexity, depending on the size of their "target" areas, the sophistication and nature of available resources, and the attitudes of local professional organizations toward them. Some large cities, for example, Chicago and Denver, have one project covering several target areas and involving the participation of several hospitals and "satellite" or neighborhood clinics. Others contain several unconnected projects, each with its own target area—as do New York and Baltimore. One city, Philadelphia, is unique in having five separate projects operated independently but planned together by the professors of pediatrics of the city's five medical schools and closely coordinated by the project directors and staff.

In some areas, as in Kansas City, Mo., children and youth projects that are hospital administered have been integrated into the hospital's pediatric clinic, the new elements being the accent on comprehensiveness and continuity provided by the use of interdisciplinary teams, the family-centered approach, the provision of well-child supervision in addition to treatment services, the followup of broken appointments, the provision of outreach services such as visual screening and nutritional education in the schools, and the development of a close working relationship with community agencies such as the community action program, a visiting nurse service, or a social casework agency. Some hospital directors of pediatrics say that by introducing such concepts the children and youth projects have revolutionized their hospitals' methods of care.

At the Children's Mercy Hospital in Kansas City, Mo., the project has added staff members to the Visiting Nurse Association and the school health program of the local school system as well as to the hospital's pediatric service. It regularly brings representatives from these and other community services such as the juvenile court probation department to its interdisciplinary case conferences.

"The big thing about the C and Y project that has permeated the hospital," a member of the project team has remarked, "is the coordination. The services were there before, but they didn't know about each other."

One voluntary hospital in another area was a white island in the midst of a black neighborhood until it began planning an application for a project and so had to look into the resources in the neighborhood. It now has black representation on its governing board as well as on its medical board. The staff of the project is predominantly black, with both professional and nonprofessional employees coming from the immediate neighborhood.

Learning how to work with members of other professions has been described by more than one project director as the most difficult, but rewarding, aspect of a children and youth project. Learning has been slower in some projects than in others because some staff members have not had previous experience in working with members of other disciplines. But in many projects, various members of the clinic staff function almost as a unit, looking together at all aspects of the patient's condition, planning together for meeting his health needs, and deciding together which team member shall carry responsibility for following through on the plan.

For example, at the Roosevelt Hospital in New York where the project's target area is divided into two parts, each part is served by a team called a "module" composed of a public health nurse, a social worker, and a nonprofessional person trained by the project as a "physician's assistant." These teams meet daily to devise a case plan for patients seen the preceding day at the clinic. Other members of the project

staff, such as the nutritionist, otolaryngologist, dentist, psychologist, or consultant psychiatrist, attend these assessment conferences, when appropriate, as do members of outside agencies, especially the guidance counselors from schools in the target areas. In all cases, however, the pediatrician who examines the child assumes total responsibility for the health care plan adopted. The project has found that including the school counselors in these assessment conferences not only brings valuable information about the child under discussion to the team, but also expedites the team's recommendations concerned with the child at school more effectively than the usual written communications between clinic and school.

Team conferences are also held on each child registered with the children and youth project at the Jefferson Medical College in Philadelphia. There the project has developed a generic interviewing instrument called a continuing care interview and has trained each team member in its use. Before any comprehensive plan is devised for a child, one of the team members interviews the child's mother, using this interview design, and then prepares a summary of the apparent assets and liabilities of the child and his family and outlines a tentative long-term plan for the child's preventive health care, which he presents to a conference of the entire team along with the results of the child's physical examination. In the ensuing discussion, the team develops a revised plan. The revised plan is later submitted to the child's family in a conference attended by the original interviewer, the pediatrician, and the specialists who would be primarily involved in carrying it out, where it may undergo further revision according to the family's interest. The staff members who attend this family conference become the family's primary care group, the persons responsible for continuity of care.

## Some impressions

A visitor to these projects cannot help but become acutely aware of the many community problems complicating their efforts to improve children's health—the meagerness of family incomes; the lack of decent housing in the neighborhoods being served; the long waiting lists at mental health clinics; the overcrowded, inadequately staffed schools; and the lack of day-care and homemaker services to relieve overburdened mothers. It is depressing to hear from a clinic director, for example, that the exceptionally good clinic attendance on the coldest days of winter may be due to the lack of heat in the families' homes.

Nevertheless, the visitor catches a sense of excitement among the people of the many professions and talents who are working together to provide total, continuous, health care to children. Apparently derived from participation in a creative experience, the excitement radiates from all types of project staff members, from directors to community aides.

One also finds evidence of enthusiasm among the people the projects serve. It is shown in the activities of parents of the children in care—of those who are participating in clinic-sponsored parents' councils to mobilize neighborhood efforts toward community improvement; of those who babysit for other mothers while they take their children to the clinic; of those who give their time in the clinic or the community as volunteer aides, supervising a play area in the clinic waiting room, assisting in mass screening programs, or knocking on their neighbors' doors in casefinding efforts. It is reflected in the "Clinic and Community Caller," a newsletter with the folksy quality of a small town newspaper, put out by the parents of children enrolled in one of the neighborhood clinics of a Baltimore project. And it comes through in numerous spontaneous comments, such as the one made by a project patient's grandmother who sighed:

"I only wish I had had this kind of care for *my* children."

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[1] Section 509, Title V, Social Security Act, as amended by P.L. 89–97, 86th Congress.

[2] Weckworth, V.: Efficiency versus effectiveness: how these interact in the administration and allocation of funds for health care. Systems Development Project, School of Public Health, University of Minnesota, Minneapolis. Comment Series No. 7–8 (1), On Allocating Resources: PPBS. March 1967.

a new look at

# THE COURTS and CHILDREN'S RIGHTS

WALTER WADLINGTON

For more than a decade, the United States has been witnessing a revolution in judicial concern for protection of the rights of the individual. In the field of criminal law, this concern has been expressed in court decisions establishing the right of an accused person to be represented by counsel in major cases, if necessary at public expense; placing limits on the State's power to conduct searches and seizures to obtain evidence; confirming the right to a speedy trial; and generally reinforcing the constitutional privilege against self-incrimination at various stages of legal proceedings on criminal charges. Although the juvenile court at first stood still in the face of the sweeping changes in the adult criminal courts resulting from these decisions, it was inevitable that some form of protection would eventually be provided to the child brought before the court designed to serve him.

The most notable steps in this movement to protect an accused child's legal rights have been made in the past few years by the Supreme Court of the United States through decisions dealing with delinquency proceedings in juvenile court, particularly in the Gault case [1] in 1967. In the Gault ruling, which holds that due process of law must be observed in juvenile proceedings, the Supreme Court found it necessary to protect the child from the very institution that had been set up to provide him with humane treatment when he is in trouble with the law.[2, 3]

The movement to protect individual rights has also reached far beyond the criminal law. In civil courts, a tendency to hear suits charging invasion of privacy or the intentional or negligent inflicting of emotional harm to another person illustrates the increased recognition of concern for protection of highly valued personal interests. In noncriminal actions dealing specifically with children, the courts have increasingly been concerned with protecting children against abuses, which may occur almost as a byproduct of laws specifically enacted for the orderly establishment, continuance, and dissolution of the family. In a sense, this concern for the protection of children in civil action is consistent with the premises of the Gault decision, which sought to protect the child against abuses in the juvenile court.

The juvenile court ostensibly derives its broad powers from the amorphous—and, some would say, false—concept of *parens patriae*, under which the State, through the juvenile judge, acts as a "good parent." In many cases in which the State takes this role, objections could be raised against either the process or the result. If this is so, is there not a need for protection of the child in some instances against his parents as well as against juvenile court judges?

To continue this analogy, the family is in fact a governmental as well as an economic and social unit. Parents have almost unlimited authority over their minor children, subject to certain established

State requirements, such as vaccination and minimum school attendance. Although parents are required to support their children, the courts enforce this obligation only in extraordinary circumstances or in flagrant cases of nonsupport. That some parents use their power in despotic fashion has become obvious and has led to the enactment of statutes in all the States to protect children against intrafamily abuse, a subject extensively discussed in previous issues of CHILDREN.[4-8]

Justification of the continued existence of the family as it is known today is frequently based on its role as the most effective unit for the procreation and training of children, as well as its role as a governmental unit *per se*. Just as the juvenile court is "for" the child, so then is the family. And so, theoretically, are the various laws that surround the creation and dissolution of the family, or that provide sanctions against procreation of children outside the particular marriage unit licensed by the State. This analysis is not intended to deny a spiritual or emotional basis for marriage, nor to imply that marriage is simply a license to breed. But in the view of our laws today, marriage is a civil institution; therefore, the child's position in the family must be considered in that context.

Before examining some recent instances in which the courts have intervened to protect the rights of children, as well as several areas where intervention seems likely to occur in the near future, it is necessary to explain why no major judicial movement to protect the rights of children occurred until recently. Regulation of marriage and the family for a long time was considered a cherished right of the States, in accordance with the reserved powers clause of the 10th amendment to the Constitution of the United States. Although this should not have been taken to mean that such Federal constitutional guarantees as due process and equal protection were wholly inapplicable to State regulation of the family, in practice the courts were reluctant to permit attacks based on such grounds. Federal courts even announced that they did not wish to exercise jurisdiction over suits that chiefly involved issues of family law.

However, recent decisions of the U.S. Supreme Court, as in the Griswold case [9] (which invalidated a State proscription against use of contraceptives by married couples) and the Loving case [10] (which set aside a State statute outlawing interracial marriage), have finally made it clear that State action dealing with the family can be challenged successfully in the courts on constitutional grounds. This judicial climate of concern for individual rights generally and of willingness to apply Federal constitutional limitations to State regulation of the family provides the opportunity for better delineating the boundaries of children's rights and broadening the legal avenues for the protection of those rights.

## Illegitimacy

One of the most substantial breakthroughs in judicial action to protect children's rights concerns the status of the child born out of wedlock. Although in general State laws have not dealt with children born out of wedlock as harshly as did the English common law, the arbitrary status of illegitimacy has nevertheless affected the child's inheritance rights as well as the obligation of the father for child support. Legislative attempts to ameliorate the hardships of the status of illegitimacy for a minor child have largely followed a pattern of trying to reduce the number or percentage of children deemed illegitimate instead of eliminating the status itself. Some very early State laws provided that the child of a void or voidable marriage would be legitimate, even though an annulled marriage is regarded as never having been performed. In 1792 a Virginia law eliminated the illegitimate status of children born out of wedlock whose parents later marry each other. Some States provided for the legitimation of a child born out of wedlock through the father's acknowledgment of paternity. However, in many States the child born out of wedlock but subsequently acknowledged without intermarriage of the parents is still generally accorded fewer rights than the child born in marriage. Discrimination against such children is particularly prevalent with regard to inheritance rights.

In 1968 the U.S. Supreme Court in the Levy case [11] squarely faced the problem of whether one type of State discrimination based on illegitimacy could be maintained constitutionally. The administratrix of the estate of five minor children born out of wedlock brought a suit for damages based on the death of their mother, who had been their source of support. The Louisiana appellate court [12] held that under Louisiana civil law only children with legitimate status could bring such an action, but the U.S. Supreme Court overruled this decision on the ground that classification by birth status for this purpose violates the equal protection guarantees of the 14th amendment. In a companion case,[13] the Supreme Court held that under Louisiana law a mother could

bring a suit for damages based on the wrongful death of her illegitimate son.

The fallout from the Levy decision already can be detected around the country. A Missouri appellate court has relied on this decision to invalidate the part of the State's support laws that distinguished between legitimate and illegitimate children.[14] A New York court has questioned a support procedure in its relatively new Family Court Act[15] that discriminates on the basis of legitimacy. The Maryland Court of Appeals has used the decision in ruling that a child born out of wedlock cannot be removed from the home of his mother solely on the basis of the birth of her second illegitimate child or another illegitimate pregnancy.[16]

Some courts, however, have sidestepped applying the Levy decision in cases in which they deem classifications based, partly at least, on legitimacy to be rational.[17] Therefore, the full impact of the Levy decision remains yet to be determined. One of the reasons most frequently given for continuing to distinguish between legitimacy and illegitimacy is the desire to punish parents for conduct that leads to the birth of children out of wedlock. It is exactly this approach, which subordinates the interests of the individual child to the system generally, that was specifically condemned by the Supreme Court in the Levy case.[18]

Another decision of the Supreme Court in 1968 followed the theme of protecting children's rights when the validity of the Alabama welfare department's "substitute father" rule was challenged.[19] The children involved had sought to enjoin the State from cutting off payments to them under the program of aid to families with dependent children (AFDC) because of the alleged immoral conduct of their mother with a man not their father.

The Supreme Court noted that protection of children was the paramount goal of AFDC and, therefore, the children's interests were not to be sacrificed because of their mother's impropriety. In short, although the State might have the power to remove the children from their home if they were in fact neglected, the children's rights under AFDC would be protected while they remained with their mother.

## Divorce proceedings

Divorce is an area in which procedures are urgently needed to protect the interests of the child more effectively. In the past, divorce often carried strong overtones of immorality; today it is viewed in most States as a social tool that is desirable in many circumstances—so long as its impact on the minor children of the marriage can be minimized. Some courts are showing concern for saving marriages in fact, rather than simply in name, through increased use of social devices such as family counseling. Usually priorities for counseling in divorce cases are given to parents with minor children. In some courts such counseling is required.

The child may need formal protection either in the divorce proceeding itself or in the preceding negotiations of financial and custody agreements that are reached after hard bargaining. Divorces that are not contested often involve "quickie" proceedings in which the judicial role may be little more than a perfunctory listening to the required corroborative witnesses and a ratifying of previous agreements made by the spouses. Even in contested proceedings the presentation of evidence and control of the case are generally in the hands of attorneys for the husband and wife, both of whose interests may be adverse to those of the children of the marriage on such issues as whether to reveal past instances of mishandling or neglect that might disqualify either parent as a proper guardian.

Recently, many judges—particularly those in family courts—have begun to obtain and use independent custody investigations in both contested and uncontested divorce proceedings. This trend reflects judicial concern that custody and support awards should be based on the best interests of the child rather than simply on a mechanical rule for allocation according to the sex or position of the spouses or on a rubber-stamp agreement made by the parents in negotiations where the child was not represented. In using an independent custody investigation, the judge recognizes that if provision for the child is simply an item thrown into the parents' negotiations, the child may be bartered for various concessions having nothing to do with his personal welfare. The investigation

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also assures the judge that he has information about important disabilities or problems of the parents relevant to the custody award.

Courts in some States have even gone beyond requiring an independent investigation and have provided separate legal counsel for the child in a divorce action. This practice raises some questions, such as whether a child's counsel should be permitted to introduce evidence of recrimination or collusion that would affect the case or to contest a divorce award as being against the child's interests. However, separate counsel—even when not given such latitude—can serve the valuable function of assuring that the child's rights are not lost in the presentations of the parents' counsels.

Providing independent counsel for the child, however, by no means obviates the need for the court to provide for impartial custody investigation. The combination of these two practices can bring to the court the facts necessary to prevent the interests of the child from being overlooked.

## Wrongful life

No doubt the most dramatic attempt to secure protection of a child's rights through the judicial process came in the Zepeda case in Illinois in 1963,[20] in which a child literally sued his father for having caused him to be born out of wedlock. After citing laws showing the State's great concern for mitigating the hardships accompanying illegitimate status, the State court concluded that the child had in fact suffered a wrong through his father. Although the court called this wrong a tort, it declined to take the next step—to permit an award of damages without specific legislative authorization—because of the tremendous implications of such a step.

The theory of the Zepeda decision has been asserted in several other jurisdictions since 1963, and its possible influence toward change does not appear to be spent. A New York State court [21] used the rationale of the Zepeda ruling in refusing to dismiss the damage suit against the State of a child produced by the rape of a mental patient in a State institution, but this decision was overruled by a higher court.[22]

In another jurisdiction, parents were unsuccessful in suing a physician on behalf of themselves and their defective child.[23] In this suit, which has been discussed in terms of a "right not to be born," the court rejected the argument that the parents might have obtained an abortion if they had been fully apprised of the fact that the German measles suffered by the mother during pregnancy might produce defects in her child.

In short, the judicial attitude in this group of cases to date has been one of "better bred than dead." However, the existence of the cases indicates the extent to which lawyers are now willing to assert the rights of children before the courts.

## Other civil actions

Although in many circumstances a child may now sue his parent in a breach of contract or other action affecting his property, there remains a general policy of parental immunity from suit for personal injury inflicted by the parent on his child. This is beginning to give way to some degree, especially in instances in which such an action will not be considered destructive to family harmony. For example, in an automobile accident in which a child might sue his parent for negligence, the latter would be indemnified through insurance. The same arguments that were used a few years ago to oppose damage suits between husbands and wives—including the possibility of collusion—are being used to oppose suits of children against their parents. However, support is growing for the idea that parent-child immunity from lawsuits should be almost wholly abolished, perhaps leaving some leeway for the exercise of parental discipline.

Courts in Illinois, Michigan, and Minnesota also have permitted children to bring actions for damages against third parties who disrupted the family home by alienating the affections of one of the parents. Other State courts have denied hearings in similar actions on the ground that the legislature, not the judiciary, should create an important policy—a philosophy similar to the court's in the Zepeda case.

## What next?

This has by no means been an exhaustive listing of the areas in which courts have begun to show increased interest in protecting the rights of the child, or of the situations in which such expressions are next likely to appear. In many areas, such as the freedom to express opinions, there seems little question that the child is accorded the same basic rights as the adult. For example, a recent Supreme Court decision upheld the right of schoolage children to protest the Vietnam war in a nondisruptive fashion by wearing black armbands, despite a contrary regulation by school authorities.[24]

Neither the cases cited nor the indication of more to come necessarily means a massive flood of litigation will ensue to tear apart existing family law. Instead the current trends illustrate a growing judicial awareness of the need for legal changes affecting the family, with a focus on protection of the child's interests. Some courts have already felt the need so keenly that they have taken necessary corrective measures in the absence of legislation, while others have chosen to prod the legislatures to act first. In any event, recent actions of the courts should give greater impetus to the general reform movement.

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[12] *Levy* v. *Louisiana*, 192 So. 2d 193 (La. App. 1967), cert. denied, 250 La. 25, 193 So. 2d 530 (1967).

[13] *Glona* v. *American Guarantee and Liability Insurance Co.*, 391 U.S. 73 (1968).

[14] *R*——— v. *R*———, 431 S.W. 2d 152 (Mo. Sup. Ct. 1968).

[15] *Storm* v. *None*, 57 Misc. 2d 342, 291 N.Y.S. 2d 515 (Fam. Ct. 1968).

[16] *In re Cager*, 248 A. 2d 384 (Md. 1968).

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[18] Krause, H. D.: Legitimate and illegitimate offspring of *Levy* v. *Louisiana*—first decisions on equal protection and paternity. *The University of Chicago Law Review*, Winter 1969.

[19] *King* v. *Smith*, 392 U.S. 309 (1968).

[20] *Zepeda* v. *Zepeda*, 41 Ill. App. 2d 240, 190 N.E. 2d 849 (1963), cert. denied, 379 U.S. 945 (1964).

[21] *Williams* v. *State*, 46 Misc. 2d 824, 260 N.Y.S. 2d 953 (Ct. Cl. 1965).

[22] *Williams* v. *State*, 18 N.Y. 2d 481, 276 N.Y.S. 2d 885 (1966).

[23] See *Gleitman* v. *Cosgrove*, 49 N.J. 22, 227 A. 2d 689 (1967).

[24] *Tinker* v. *Des Moines Independent Community School District*, 89 S. Ct. 733 (1969).

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. . . development of a far broader range of alternatives for dealing with offenders is based on the belief that, while there are some who must be completely segregated from society, there are many instances in which segregation does more harm than good. Furthermore, by concentrating the resources of the police, the courts, and correctional agencies on the smaller number of offenders who really need them, it should be possible to give all offenders more effective treatment.

A specific and important example of this principle is the Commission's recommendation that every community consider establishing a Youth Services Bureau, a community-based center to which juveniles could be referred by the police, the courts, parents, schools, and social agencies for counseling, education, work, or recreation programs and job placement.

The Youth Services Bureau is needed in part because society has failed to give the juvenile court the resources that would allow it to function as its founders hoped it would. In a recent survey of juvenile court judges, for example, 83 percent said no psychologist or psychiatrist was available to their courts on a regular basis and one-third said they did not have probation officers or social workers.

***"The Challenge of Crime in a Free Society," a report by the President's Commission on Law Enforcement and Administration of Justice, February 1967.***

two child psychiatrists, a pediatrician, and a social worker consider the meaning of . . .

# INFORMED CONSENT in PEDIATRIC RESEARCH

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In recent years, several exploratory studies of conflict between research and social values have been carried out. Some of these studies have been focused on behavioral research;[1-3] others, on certain nonbehavioral aspects of pediatric research.[4,5] In pediatric research the principle that "informed consent" must be obtained from the parents of the child who is a research subject, and, where appropriate, from the child himself, has become accepted as an ethical necessity. The question, however, remains as to the *meaning* of informed consent in the context of pediatric research. Herein lie some difficult issues.

The purpose of pediatric research is to clarify problems in understanding normal and pathological processes and in the diagnosis and treatment of disease. Such research has the ultimate goal of benefiting individual children, even though the child who is a research subject may derive no benefit from it.

When and to what extent is subjecting a child to pain and anxiety justifiable? A simple guideline might be: When there is no possible benefit to the child, then any procedure that harms the child in any way is categorically unethical. What constitutes "benefit" and "harm" of course remains to be defined in the individual case. Moreover, this guideline leaves unresolved the question of the conditions under which the parent has the right to give consent for research to be performed on his child when the research cannot help the child but holds out promise of great good for many other children. The fact is, there is no simple guideline.

Some medical writers have approached this question in a general way by suggesting some preliminary considerations—such as the design and value of the research and whether, if it has been done before, it is worth repeating—to be followed by an evaluation of the physical and psychological risks for the child. Psychological hardship for the child, sometimes amounting to trauma, may be caused by many factors, such as the nature of the specific research procedures, the child's separation from his mother, changes in the child's environment, and possible shifts in family relationships or intensification of conflict in the parents' feelings about a defective child.[6]

The nature of "informed consent" has also been approached in a general way. For example, a declaration adopted by the Council of International Organizations for Medical Science states:

> **If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation . . . . However, the responsibility for clinical research always remains with the research worker; it never falls on the subject even after consent is obtained.[7]**

And a report of the British Medical Research Council states:

> **By true consent is meant consent freely given with proper understanding of the nature and consequences of what is proposed. Assumed consent or consent obtained by undue influence is valueless and, in this latter respect, particular care is necessary when the volunteer stands in special relationship to the investigator, as in the case of a patient to his doctor, or a student to his teacher . . . . In general, the investigator should obtain the consent himself in the presence of another person.**[4]

The value of such statements is limited by their lack of specificity. They also fail to mention a further general but important concept: Truly informed consent cannot be confined to a single moment in time; it is a continuous process, subject to modification and even at times withdrawal, depending on changes in the conditions of the subject and the research.

## Some relevant issues

***Investigator's awareness.*** Several perplexing issues confront the investigator as he seeks to obtain informed consent from the subject.

1. Because advancement on a medical faculty today largely depends on demonstrated productivity in research, a sense of urgency may subtly influence the investigator's presentation of his proposed studies. An investigator needs a high level of self-awareness, as well as integrity, to determine the degree to which his studies serve the needs of children as distinct from his own needs for advancement.

2. Distinguishing the study aspects that might be expected to benefit the child directly from those that may only benefit other children in the future is often difficult. Because it is easier to discuss with a parent a research protocol that will result in direct benefit to the child involved, an investigator may perceive benefits in his research that may not so readily be perceived by physicians unconnected with the study.

3. When the research is concerned with a rare condition or a little-tried therapeutic agent, the basis for a complete assessment of physical risk may be inadequate. Assessment of psychological risk may offer even greater difficulty, since the investigator may have had little training in this work.

4. Effective communication with the child or his parent may not occur. Even the most conscientious and thorough presentation of the purpose of the research and the procedures and risks involved may be insufficient; the reactions of the child or his parents during the explanation must be understood. A careful interview technique is required for perceiving symptoms of an anxiety that may be preventing the subject from hearing, understanding, and remembering the facts being explained to him. Training in such interviewing has seldom been a part of the investigator's preparation.

***Involving the child.*** Can one ever have the truly informed consent of a child? Most investigators make a judgment as to how much information to convey to a child and how much consent to expect from a child. The factors that are usually weighed include the child's age and developmental stage, his level of anxiety, and the degree of emotional support he receives from his parents.

Schoolage children should in some instances be involved in the consent procedure. However, children, as well as adults, need time to comprehend and accommodate to a research plan and procedures. This means that much of the protocol and much of the consent must be broken down into assimilable parts, with the investigator making his judgments at many stages during the research.

***Parental consent.*** The final responsibility for giving consent rests with the child's parents or guardian. However, many factors interfere with their capacity to give truly informed consent. Their lack of medical background limits the ability of many parents to understand the nature, aims, and methods of the proposed research, or the possible benefit to their child. Their anxiety about their child and their expectation that research implies "using" the child as a "guinea pig" may further limit their capacity to assimilate explanations. Moreover, they may see no alternatives to consent. For example, some parents regard the suggestion that their child be hospitalized as a research subject as confirmation that the child is seriously ill and may therefore feel that they will be doing the child a disservice if they do not comply. Some parents are prepared to give consent to a trial therapy but feel the therapy will only be made available if they consent to a broader research protocol.

The enticement of obtaining free medical care for the child because he will be participating in research may influence the parents' decision. Conversely, some parents feel less in control of the situation, and more anxious, when they are not required to pay a fee.

Parents are not always aware of the potential psychological stress the procedures may impose on their child. An occasional parent in consenting to the re-

search may be acting out unconscious hostile wishes against the child or may be influenced by anxiety, guilt, and depression. Ethically, the child should not be regarded as the property of the parent to be used as a means to the parent's ends, but should be approached as an individual person with his own specific needs and anxieties.

A parent may ask himself, or may be requested to ask himself: "Are the research procedures that are being considered for my child the kind I would consent to have performed on myself as a child?" This question, however, does not provide a true test of informed consent for the following reasons: (1) neither the parents nor the physician may comprehend the psychological issues involved in consent for oneself; (2) the needs and anxieties of a child are different from those of an adult, and, in some instances, the child cannot speak meaningfully for himself, either about his anxieties or about the proposed research; (3) in considering only his own feelings about the procedures, the parent may be regarding the child as his property rather than as another human being with needs and feelings of his own.

Parental consent, therefore, cannot be regarded as "informed" until parents have had time and opportunity to understand the nature of proposed research, their feelings and attitudes about it, its relevance to their child's medical needs, and its physical and psychological risks in relation to their child's stage of development and personality structure; and to consider alternative sources of appropriate medical care.

A few brief case examples will illustrate some of the complexities involved in the meaning of informed consent. They are presented with the parents' permission and, in one case, the adolescent child.

## Changing meaning

The following case illustrates how the meaning of informed consent can undergo changes when uncertainties about the risks of therapy create anxiety in both the patient and the parents, resulting in a weakened sense of trust in the investigator.

A 14-year-old girl who had a brain tumor partly removed at the age of 4 had been under the observation of a pediatric endocrinologist for 2 years. She and her parents became increasingly concerned because of her lack of adequate growth and sexual development. Her delayed development was producing serious psychological and social difficulties for her. Therefore, the parents urged the endocrinologist to consider treating the girl with growth hormone.

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The endocrinologist pointed out that growth hormone was available for therapy only in research, thus necessitating the acceptance of a research regimen for the patient and that its use might be associated with some danger since the few data that were available indicated that it might enhance tumor growth. He explained that because of the risk of tumor growth, he was reluctant to institute the therapy until he could obtain more information from colleagues around the country. The parents had understood from the patient's pediatrician and neurosurgeon that the growth hormone therapy would be appropriate and would involve little risk. Therefore, the delay in instituting the studies engendered mounting anger and anxiety in the family.

When the endocrinologist felt assured that the risk of tumor regrowth was small, he again reviewed the plans for study with the patient and her parents, and arranged for her admission to a pediatric research center.

In this conference, the patient and parents had given formal consent. However, in the preadmission interview with the research center social worker, the parents showed evidence of a marked increase in anxiety. This was expressed in several ways. They seemed angry with and mistrustful of the endocrinologist, with whom they had previously had a good relationship. They complained of his style of communication, apparent reluctance to proceed, and lack of clarity about the procedures involved in the research. They indicated their inability to comprehend the protocol because of its highly technical language. They indirectly expressed fears that their child might die as a result of the treatment, and they reported personality changes in her that they thought reflected either a breakdown in her ability to cope with difficulties or brain changes associated with tumor regrowth. The

mother feared that her own psychological integration might be compromised if things did not go well for her child.

At the request of the investigator the patient was examined by the child psychiatrist. She proved to be a bright, somewhat compulsive girl, who was able to express her feelings vividly. During her first week in the hospital, she described feelings of moderate bewilderment and said that she had "never felt so nervous" in her life. She was particularly afraid "for some unknown reason" of having a glucose tolerance test. Gradually the reason for this particular focus of her fear became known. The investigator had at one time expressed uncertainty as to whether the test would be performed. Now the patient wondered whether she was being made a guinea pig. This set off a chain of other fears. Would she get sick? Would the hormone make the tumor grow? Would she then die? How safe was she, and who would take care of her? Would her mother stay with her? Would the hormone help her? She doubted the good judgment of her parents because she knew they did not know exactly what to expect.

Afraid of the research, this patient was at the same time afraid that she would lose her friends because of her small size, lack of development, and disinterest in such feminine preoccupations as clothes. She also felt unable to meet her parents' academic aspirations for her. Her depression, fears, and anxiety not only made her unable to ask the investigator questions but also led to a helpless compliance.

Soon after the patient's admission to the hospital more data on the growth hormone became available, confirming the assumption that its use carried few risks. This information, plus the genuine concern demonstrated by the endocrinologist, helped the parents reestablish their previous trust in him and made for a much smoother hospital course for the girl.

In this case, the investigator's task of assuring that the consent to the research was made on a truly informed basis became difficult because the procedures contemplated involved risk but no guarantee of gain for the child, thus creating anxiety in both parents and child.

The meaning of the parents' consent underwent several changes that reflected an increase in anxiety and concomitant distortions in judgment. Although highly intelligent, the parents could not understand the protocol outlining the clinical procedures that would take place, primarily because of their anxiety.

The 14-year-old patient was capable of a great deal of understanding and clearly benefited from the psychiatrist's help. However, because of the suppressed anxiety she was experiencing, her initial consent was less meaningful than it appeared. When she was confronted by the reality of the procedures, increasing anxiety altered her perception of the research.

Thus, a succession of attitudes may occur. Initially, the child may feel anxious about the proposed research. However, before he has been confronted with any of the actual procedures, he may find it easier to deny his anxiety and so consent to the research. As the research approaches, his level of anxiety may rise, thus weakening his consent and perhaps leading to a wish to retract. Once the first procedures are completed, the patient's anxiety may abate, changing once more the meaning of his consent.

## The child's interests

While the parents and investigator may have a contractual agreement based upon apparently informed consent, it does not follow that this consent is necessarily in the child's best interests. In some instances, psychiatric evaluation of a child's capacity to cope with the hospitalization may be indicated before admission. These points are illustrated in the following case.

Research procedures were suggested for a 7-year-old extremely obese, short girl to rule out the possibility of a brain tumor or other organic disease and to establish whether treatment with growth hormone was indicated. The parents gave their consent after the investigator had carefully gone over the complex technical research protocol with them. However, in the preadmission interview with the social worker, they showed signs of being seriously confused and anxious about the procedures. They feared that lethal air bubbles would result from the intravenous infusions or brain damage from the electroencephalogram. Their consent, obviously not "informed," seemed based on the expectation that if the child gained weight without growing she would become unable to move and would develop dangerous heart disease.

Because these parents described their child as enuretic and prone to night terrors and temper outbursts, suggesting that she might be overwhelmed psychologically by the studies, a child psychiatrist was asked to evaluate the child prior to admission. The social worker held several interviews with the parents to clarify their fears and misconceptions.

Their daughter, Alice, a child of above average intelligence, understood that the doctors "might" be

able to find something to help her grow, but she definitely did not want to go into the hospital. However, she said that if there were not "too many needles" and if she did not feel them too much, she would go into the hospital for the 17 days required. She dealt with her anxiety through an obsessional accounting of the procedures to be followed in the hospital. She told the psychiatrist she wished her parents would stop talking about the hospitalization and would "hurry up and get it over with." On the whole, she showed good judgment and an ability to cope with stress.

Because the physician-investigator was concerned about the possibility of a brain tumor and because the family was under considerable stress, the psychiatrist recommended that the child be admitted to the hospital as soon as possible. A plan for collaborative supportive care between the social worker and the psychiatrist was carried out during and after hospitalization.

Here, the initial consent of these parents was meaningless because of their emotional disturbance, but the child was able to understand the nature of the research, and was further prepared for it by the child psychiatrist. This preparation was especially important because of the urgent medical indication for proceeding.

## Special arrangements

In some instances, it may be important to design a therapeutic nursing regimen before hospital admission to safeguard the child's psychological integrity, as in the following case.

A mother gave consent for hospitalizing her 7-month-old infant son, David, for study and surgery. The child had Cushing's disease, a serious endocrine disorder. The hospital regimen would include motor restraint on a metabolic mattress—a device for collecting feces and urine—thus subjecting the child to the risk of social isolation.

David had reached that developmental stage in which children are wary of strangers and so was particularly vulnerable to intense separation anxiety. However, his mother, who was attending school, maintained that she could make only brief evening visits to him a few times a week during the proposed 2-month hospitalization period. She had already turned most of the daily tasks of the child's care to her own mother. David's urgent need for medical treatment precluded any delay in hospitalization pending efforts to change his mother's attitudes.

Because this mother gave consent to the research without providing any safeguard for the child's psychological development, the pediatric investigator, social worker, nurse, and pediatric child development specialist collaborated in instituting a therapeutic regimen to meet the infant's developmental needs. This regimen consisted of: (1) encouraging the mother to be warmly attentive to her child during her visits and to give clear signals to him when she was about to leave; (2) assigning the same nurses to the child on each shift; and (3) providing the child with tactile, visual, verbal, and social stimulation through the provision of toys and caressing, massaging, and other forms of attention from staff members and other patients. David was also regularly moved from the metabolic mattress onto a potty in a carriage, thus allowing him more motor activity and changing his environment from a depressing, monotonous one to a more interesting one. David made appropriate developmental gains in the 2 months he was in the hospital.

## Interruption of research

In some instances, a child's responses to the stress of the research may require the studies to be terminated before completion, as it was in the following case.

Charles, a blind 7-year-old boy, was expected to die within the year from an inoperable brain tumor. Charles' mother gave consent for the boy to be hospitalized and subjected to endocrine studies that could not benefit him in any way. The justification for the studies was the possibility of their leading to earlier identification of brain tumors in other children.

The mother's motives in giving her consent for the studies were complex. She told the staff that she felt Charles' life would have been worthwhile if, through the studies, it led to knowledge that would benefit other children. This statement implied that her consent was partly a way of dealing with Charles' impending death (although Charles would die, the knowledge gained through him would live on) and partly a way of compensating for his loss (Charles would die so that other children might live). However, the statement also implied the existence of unconscious anger toward Charles, since it disregarded the severe stress to which the child would be subjected.

The psychological stress proved to be particularly severe since the medical procedure heightened the

fears commonly experienced by a child at Charles' developmental stage—concern about body intactness and manipulation. Frequent venipunctures, necessary for the research, led to acute panic states in the child. Moreover, the usual means of dealing with such stress through play, visual, auditory, and tactile experiences, and motor activity were denied to Charles by his blindness and the imposed restraint necessary to the procedures.

When Charles was threatened with further restraint because reaching his difficult veins satisfactorily would require cutting through his skin, the investigator terminated the research.

In this case, recognition of the incomplete resolution of the mother's feelings about her child's impending death, developmental anxieties in the child, and the acute stress imposed by the procedures led the pediatric investigator to decide to discontinue research that could have no direct benefit to the child.

## Recommendations

In view of the difficulties involved in determining the meaning of informed consent, we suggest the following safeguards for children being considered for participation in medical research:

1. The nature of the research design and all risks to the child should be assessed by a review committee that includes pediatric investigators who are not involved in the research as well as the pediatric investigator who is to conduct the study. This will provide safeguards against the investigator's inevitable bias and gaps in knowledge.

2. The review committee should include a professional person especially equipped to assess the psychological risks to the child. This person would have to be aware of those areas of development especially vulnerable to impairment at the child's developmental stage, have the interviewing skill required for assessing the child's degree of vulnerability, and understand the kinds of stress likely to be provoked by the research procedures.

3. The investigator should have a series of personal interviews with the parents and at times with the child to build a relationship of trust, and establish an understanding of the research goals and methods and of the risks involved.

4. When the investigator lacks the skill or experience necessary for preparing the parents and the child for the research, correcting their misconceptions about it, and dealing with the child's reactions as the admission date approaches, a social worker and a psychiatrist may be called upon to help fulfill these functions, in supplementary preadmission interviews.

5. The investigator, research director, nurse, social worker, and psychiatrist should plan in advance for the child's care in the hospital since special arrangements may be required to prevent impaired development.

6. The research team should include a pediatrician, nurse, child psychiatrist, child psychologist, or social worker to provide a continuing evaluation of the psychological reactions of the child and his parents to the research procedures and to train research personnel in the early recognition of emotional stress and ways of dealing with it.

7. The activities of all the staff members on the research team should be coordinated in regularly held interdisciplinary conferences.

8. Followup care should be provided to deal with whatever reactions to the research procedures may occur after the child's discharge from the hospital.

9. Parents and staff members should have an understanding of what parts of the psychological information revealed during the research are to be shared with other members of the staff and what parts will remain in confidence; and all staff members should understand the need for discretion in divulging such information.

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a social worker's observations on the why and how of . . .

# INVOLVING PARENTS in THEIR CHILDREN'S DAY-CARE EXPERIENCES

MARGERY M. LARRABEE

We hear a great deal today about "parent involvement" in programs for children. Nowhere, perhaps, is it more important to encourage such involvement than in programs providing day care for young children, whether this care is provided in day-care centers or in family day-care homes.

The role of a day-care program is to supplement the parent's role and not to substitute for it. The preschool child needs especially to be aware of himself as a part of a family group, for it is within the family that he begins to build a sense of his own identity. His parents remain a primary source of guidance and protection and primary models for behavior. Because a day-care program necessarily includes a number of important parental responsibilities, the parents need to understand what the child's day-care experience is so that they can build on it, help the child work out his problems, and enjoy his progress.

Day-care personnel—that is, the staff members of day-care centers or the day-care mothers in family day-care homes—need to know the child's parents and relate what they do with the child to what the parents do so that the child's developmental needs can be satisfactorily met.

The child in day care lives in two different worlds. What happens to him in his day-care placement affects what he does at home. What happens to him at home affects what he does in the day-care setting. When there is cooperation and good feeling between the mother and the day-care personnel, the child can sense a continuity in caring and a greater consistency and stability in his daily experience.

## Source of observations

The successes and failures of one agency—the New Castle County Office of the Delaware Department of Public Welfare—in involving parents in their children's day-care experiences may be helpful to other day-care sources that wish to promote greater parent participation. Through its Division of Child Welfare, the department has since 1964 been placing children in licensed nonprofit day-care centers, licensed proprietary day-care centers, and agency family day-care homes. Previously, the department's only day-care activities were in licensing and relicensing day-care facilities and providing information and counseling regarding day care to families and organizations.

After the 1962 amendments to the Social Security Act made Federal funds available for developing day-care services, the welfare department expanded its day-care service in three ways:

1. Establishment of a continuing service to families who needed day care for the children. This service included: (a) preplacement counseling provided by a day-care social worker; (b) placement of children in day care, according to a signed agreement between the agency and the responsible caretaker of the child; (c) assumption by the parent or guardian, through a written agreement, of whatever portion of the day-care fee he could afford according to a standardized budget guide; and (d) further contacts as needed between the mother or other responsible person and the department's day-care social worker, with at least one interview required every 3 or 4 months. (None of the day-care facilities in the community had social workers on their staffs.)

2. Development of family day-care homes. The use

of these homes was limited to families involved in the continuing day-care service.

3. Purchase of day care in any licensed day-care center. The department had no center of its own.

From the start of this service in 1964, the agency had a broad intake policy designed to serve families in all segments of the community. The program had no economic or social means test. Willingness on the part of the child's mother, father, or other caretaker to have continuing contacts with the day-care social worker was required.

In the beginning of the program, the department received only a few applications for day-care service; most of these families were not receiving any other services from the department. Their interest had been stimulated by department contacts with a few churches and day-care centers. However, after a referral system was worked out between the department's public assistance and child welfare divisions, the applications for day care increased. By the fall of 1967, referrals from public assistance and direct applications from people not otherwise known to the department were about equal. There were also some referrals for day care from the child welfare division and from other social agencies. Eventually applications grew beyond the number that could be satisfactorily handled by the limited staff funds and day-care spaces available. The department did not change the broad intake policy of its continuing day-care service, but in practice it tried whenever appropriate to refer families to other day-care resources that would meet their needs, providing counseling and information to the families so referred. The department preferred to reserve its day-care placements for children receiving other department services or for children needing day care because of special economic, social, or psychological needs in their families.

## Parent involvement

The observations are based on the first 3 years of the day-care service.

In those years many parents who came for day-care service needed help with the entire day-care fee. Others were able to pay part of the fee and did so. A few paid the entire fee themselves but sought the department's help in planning for the day-care placement and in dealing with family problems in child care and parent-child relationships.

Parents who were not interested in having continuing contacts with the agency were not helped in meeting the day-care fee, but they were given information and counseling regarding day care.

The department provided day-care service for families in a wide range of circumstances: where the mother or father was the sole wage earner; where the mother was working out of real economic need to supplement the family income; where the mother chose to be out of the home to meet her own personal needs; where the mother sought relief from child care to devote more time to another family member, such as a sick child or her own mother or father; where the child was not getting the kind of stimulation required for optimum development.

In a number of situations the day-care service had a therapeutic purpose and effect—where the family atmosphere was charged with emotional problems; where poor family relationships interfered with child-rearing functions; where a child with a mental, physical, or emotional handicap needed experience that the parents could not provide at home; where the child was subject to abuse or neglect. In some of these situations, the day-care placement became a bridge for moving a child into or out of a foster home.

## Problem areas

Out of the department's experience in providing this day-care service, various kinds of problems that parents face in placing their children in day care can be identified—problems that underscore the importance of involving parents in their children's day-care experience. These include:

1. Psychological and emotional problems arising for the mother because of placing her child in day care: a sense of loss or guilt; a sense of inadequacy as a mother; a feeling of rivalry with the child's day-care supervisor.

How the mother feels about the day-care placement can affect the child's adjustment. For example, one mother in a well-functioning home became so jealous of her child's teacher in a day-care center that the child stopped talking about what went on in the center and became extremely reluctant to attend. The social worker helped the mother understand the difference between the teacher's and the mother's roles and see the importance of allowing her child to enjoy and profit from her experience in the center.

2. Difficulties with the child at home arising from differences between the living standards in the home and in the day-care center.

An overburdened mother may resent a child's demanding things requiring changes in her home management patterns—such as cleaner clothes, good hot meals, regular times for washing hands and brushing teeth. In such instances, the social worker helped the mother understand the effect of these differences on the child and how to deal with them without undermining her own self-respect. In some instances, a resentful mother was eventually stimulated to improve her home management standards.

3. Differences between the expectations of the parents and the day-care personnel in regard to the child resulting in changes in the child's behavior unacceptable to his parents.

For example, an inhibited child who had little speech, poor mobility, and a bland expression on admission to day care blossomed out under the center's stimulation, becoming much more active and talkative and occasionally getting into mischief. Only after several interviews with the social worker, focused on the mother's smothering possessiveness in regard to her child, did the mother decide not to remove the child from the center.

Sometimes the differences are reversed, as when the family sets no limitations on the child's behavior and the day-care center institutes some controls. In such instances, a different set of problems ensue.

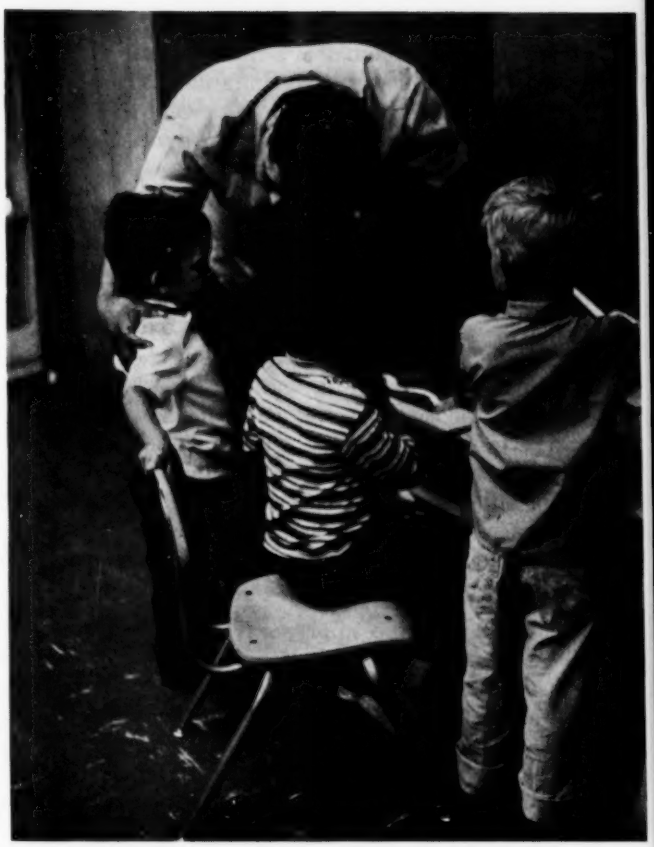
4. An emotional estrangement of the mother and child from each other, created or aggravated by the mother's becoming cut off from the child's daily experiences.

For example, the two young children of a socially active, working mother, who treated them well but in a preoccupied way. The children adjusted by a kind of withdrawal from their mother to the emotional sterility of a home life in which there was little interpersonal communication. Because the children did well in the center and caused no problems at home, this mother could see little need of the social worker's efforts to encourage her to take greater interest in the children's experiences in day care.

Such situations are not uncommon in one-parent families where the remaining parent goes out to work; they call for efforts to help parents build a psychological bridge between their children's life in day care and at home.

5. Unmet needs of the mother herself, which interfere with her ability to give the child the loving attention he needs at home.

The mother may have a psychological need for a sense of her own worth, of belonging to society, or of direction. The mother may have a practical need for an opportunity for recreation, employment, or the development of work skills. In such instances, helping the mother first meet her own needs often resulted in improving her ability to care for her child.



**Fathers, as well as mothers, sometimes get involved in children's day-care experiences as in this Head Start project.**

For example, the social worker helped a mother of six schoolage and three preschool children meet some needs that were contributing to the sense of hopelessness that was impairing her child care ability. After two of the youngest children were placed in day care and the mother was given a chance to test out some job training and to have some social experiences, she developed better attitudes toward her children, asked questions about how to handle them, began to mobilize her own resources, and to put her major effort into homemaking.

Many other mothers with similar needs responded

positively to a personal interest in them as people, but unfortunately the mother's readiness to improve her family situation was sometimes undermined by the inadequacy of community resources, such as decent housing or appropriate employment or social opportunities.

6. A negative behavioral response to day care on the part of the child, stemming from psychological or practical problems in the home.

For example, a pampered child of an overprotective mother roved about restlessly in the day-care center, bullying other children; another child, ill-prepared by his mother for the day-care experience and left too long in the center each day, acted flighty and ill at ease. In such instances, the social worker helped the mothers see the origin of their children's adjustment difficulties and ways of easing the child's transition between home and day-care facility.

7. Fathers' difficulties in assuming their rightful role as parents.

In many families applying for day care, the father had either absented himself from the home altogether or avoided any active participation in family life, often with detrimental effects on a child's development. For example, a little girl whose father had left home spoke only with great difficulty at the time she entered day care. Psychological help secured for her was of no avail until the father returned home and took an active part in the family life.

Because the importance of the father to the child's development is so often overlooked, the day-care social worker tried whenever possible to involve the fathers in the day-care planning as a way of promoting greater participation on their part in the children's daily lives.

## Roads to involvement

How can parents best become involved in their child's day-care experience? For different parents the answers are different. What leads to involvement for one parent may not for another, depending on the parent's interest, experience, personality, degree of readiness, and the presence or absence of deterrents.

The continuing day-care service in the New Castle County welfare department tried to engage the parents in the child's day-care experience from the time of application. Before any decision on placement was made, the day-care social worker discussed the nature of the service with the applicant, the possible effects of a day-care placement on the child and the family, the fee policy, and the expectations of day-care social workers having continuing contacts with the family.

Thus, the mother (or sometimes, the father) was involved in the planning and decisionmaking from the start. When a placement was decided on, the social worker arranged for the mother and child to visit the day-care facility together and apprised the mother of the importance of preparing the child for the separation and for the experiences he would encounter in the day-care center.

Such an intake process can be an important first step in encouraging parents to take a continuing interest in their child's day-care experience. The members of the day-care center staff or the day-care mother can increase the parents' involvement by reaching out to let them know the nature of the program and its expectations of the child and by the showing an interest in the parents as individuals. This, of course, happens most naturally when the mother herself, or the father, takes the child to and from the day-care facility every day. Through such daily visits the mother catches the atmosphere of the program and what is happening to her child and the child becomes aware of the connection between his life in day care and at home. When day-care staff members or family day-care mothers make something special out of greeting the mother each morning and afternoon, the mother's relationship to the day-care program is strengthened. Unfortunately, the opportunity to use such informal contacts consciously to help parents become closer to their children's day-care experience is often overlooked.

When mothers have been assured of their acceptance by the warmth and openness of the day-care personnel, they usually respond to opportunities to observe their children or participate in the day-care program. Some mothers may be interested in working as part-time or full-time day-care volunteers or as full-time paid aides. Others may simply wish to observe their children as they engage in the program. Some may go on field trips with the children or take part in other special events such as a Christmas party.

Parents can, of course, also become more closely involved in their children's day-care experience through regular individual conferences with the teachers or family day-care mothers, through organized meetings for all the parents of children in day care, and through mothers' discussion or activity groups.

All these experiences can help keep the mother close to the child who is away from home all day,

improve her skill in child care, and increase her sense of acceptance and worth. Working parents can be provided opportunities for such experiences through appointments for visits on their days off from work or through special arrangements made with their employers.

Day-care personnel can also learn from parents. Parents can show them ways of bringing the children's day-care experiences closer to home by using features from the families' specific cultural or social backgrounds—songs, stories, food prepared in special ways. Mothers who are skilled in sewing can show other mothers how to make or fix their children's clothes. Parents can also be helpful to the day-care program by effectively reaching parents whom the day-care personnel have been unsuccessful in reaching.

Getting parents involved in the day-care program requires an awareness on the part of the staff of the deterrents to involvement and how they may affect particular parents. Such deterrents include:

- Social deprivation and inexperience.
- Lack of any felt need to be involved.
- Fear of involvement.
- Preoccupation with family or work responsibilities or both.
- Fear of being expected to change, to go to work, or to give up the children altogether.
- An inability to participate because of an overwhelming sense of inadequacy or hopelessness.
- A reluctance to take on any more responsibility.

Many mothers, of course, are affected by none of these deterrents and are eager to participate in the day-care program. Others are very difficult to interest. But in either case, the staff needs to recognize the mother's interest or problem and draw her in by being available to her and by offering her the kind of experiences that will have meaning for her. Often the mother herself will provide the key as to what method will work.

## The social worker's role

A social worker can play a major role in keeping parents involved in the child's day-care experience. He can begin this effort with the intake process that has been described. He can continue this effort by passing on to the parents information about the child's behavior and progress gained from his own observation of the child and from his discussions with the day-care teachers. He can help the parent understand and use this information to keep in close communication with his child. He can help the day-care staff members, including family day-care mothers, understand the child and parents more fully so that the program can meet the child's needs.

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In the continuing day-care service of the New Castle County Department of Public Welfare, social work was viewed not only as a therapeutic and problem-solving process but also as a means of helping families sustain healthy life patterns and make the best use of the day-care experience. The social worker's help was especially sought by parents in the following areas: (1) preparing for the day-care experience; (2) understanding the child's developmental needs and how to cope with specific behavior patterns; (3) learning about the child's day-care experience and how to build on it in the home; (4) understanding their own roles as parents; and (5) finding support in fulfilling their own personal needs.

In interviewing parents, the day-care social worker generally kept attention focused on the child and his use of the day-care program, but family problems that were interfering with the child's progress also were considered. Sometimes the day-care social worker worked with the parents directly on such problems, but if a social worker from another service or agency was already involved with the family, the two social workers held a conference to plan how to help the family. In some instances, such social work efforts played a critical part in keeping a floundering family together.

The day-care social worker used both casework and group work methods. She always saw the parents individually at intake and in subsequent interviews when something was impeding the child's progress in day care or the parents' involvement in

the day-care program. These interviews were sometimes held in the social worker's office, sometimes in the day-care center, and sometimes in the family's home, depending on the need of the parents and the kind of support they required.

The group work method was used primarily for continuing contacts with parents, but also at intake. The social worker conducted small meetings in which the parents discussed the children's developmental progress and ways of meeting child-rearing problems. In a few instances, the social worker also participated in parents' meetings conducted by the day-care teachers.

In both the individual and group interviews with the parents, the social worker encouraged the parents to take some responsibility for maintaining good day-care standards. When they showed concern about the quality of health inspection, the adequacy of the supervision afforded the children in the early morning hours, or the way a teacher was treating a child, the social worker helped them find ways of taking constructive action to correct substandard conditions. In some instances, a mother's experience in working for improvements in the day-care program led to a continuing interest in community action.

The social worker through the licensing process also encouraged the day-care center staff to respond creatively to the interest and demands of parents.

## Some problems

A major problem in Newcastle County's continuing day-care service was the lack of consistent cooperation between the day-care social worker and the staff of the day-care centers—a problem that impeded the efforts to get parents involved in the program. This lack stemmed largely from the facts that the social worker was not an integral part of day-care operations—being on the staff of the welfare department rather than of a day-care center—and that her services were tied to the provision of financial assistance for day care. Following are some examples of the obstacles the social worker faced:

1. A tendency of day-care personnel and parents to carry over to the social worker a general feeling of mistrust of all public welfare workers.

2. Differences in points of view on parental responsibility between the social worker and the day-care personnel. On the one hand, there was the center director who believed that all mothers receiving public assistance should go to work, while the social worker was encouraging every mother who applied for day care to consider all alternatives; on the other hand, there were day-care staff members who put pressure on parents "to get the most money from the welfare," while the social worker was trying to help the same parents contribute to the day-care fee according to the established sliding scale.

3. Pressure exerted by some centers on the welfare department to fill vacancies with children of public assistance recipients (for whom the department would pay the full fee) regardless of how far the children lived from the center and regardless of the day-care needs of children in the center's immediate neighborhood.

4. Confusion about the social worker's role, resulting in the day-care teachers sometimes assuming the social worker's responsibilities and sometimes expecting the social worker to provide more service than was possible.

5. A communication lag between the social worker and the day-care teachers and between the social worker and the parents.

Though much was accomplished, these difficulties could not be completely overcome because of the social worker's remoteness from the day-care setting. The social worker could not achieve in the minds of parents and day-care personnel the same kind of connection with the day-care program as does a social worker who is a staff member of a day-care center. When a social worker is trying to serve several day-care centers that can not afford a social worker of their own, he might achieve a closer relationship with both clients and staff if he were employed directly by the agencies in a cooperative arrangement or if he were on loan from another agency to the centers as a shared full-time staff member.

A close association with a day-care program can expedite a social worker's efforts to involve parents in their children's day-care experience. Such efforts are crucial for the child. For unless the child finds a connection between his experiences at home and away from home, he may gain little of lasting value from the day-care program and the quality of his relationship to his parents may be diluted.

# FAMILIES of CHILDREN IN FOSTER CARE

SHIRLEY JENKINS • ELAINE NORMAN

In many inner-city areas in urban centers throughout the country, large numbers of children continue to enter foster placement each year with accompanying disruption of continuity of family patterns of child rearing. The continuing need for an extensive child welfare system of substitute care indicates not only individual failure of parents to carry out their roles, but also the increasing social and economic pressures experienced by a population living at a marginal level. The research reported in this article is part of a study of 624 children under the age of 13, who entered foster care for the first time in New York City in 1966. As such, it has implications for any large metropolitan area with comparable social indicators of poverty, mental illness, sizeable minority populations, and insufficient community-based services.

The data gathered by the research staff are derived from the family study of the Child Welfare Research Program at the Columbia University School of Social Work. The overall program encompasses a longitudinal study of the parents of placed children, the children themselves, and the activities of the placement agencies that have cared for them. The research is primarily supported by a Federal grant from the Children's Bureau.

The findings reported here are based on interviews with 390 parents of children in the study sample. Field interviews were conducted by trained social workers who made home visits and spent an average of 2 hours with each person interviewed. The respondents included 297 mothers of the placed children, 137 fathers, and 44 other persons, chiefly grandparents. In 88 cases both the mother and the father of the child were interviewed.

The data presented here are the results of the first round of a series of three field visits. The second round has been completed and is now being analyzed. The third and final interview will be undertaken at the end of the 5-year study period. The first interview collected baseline data in the following areas: circumstances surrounding placement; feelings of the parent on the day of placement, or "filial deprivation"; [1] attitudes toward agencies; basic social orientation; child-rearing attitudes; preferred child traits; socioeconomic circumstances; and basic demographic characteristics.

## Characteristics of parents

The findings show that ethnic groups and religion tend to be important differentiating variables that are related both to the families' socioeconomic status and their reasons for placing their children in foster care. Among the mothers interviewed, white mothers made up 27 percent of respondents; Negro mothers, 42 percent; and Puerto Rican mothers, 31 percent. Mothers and fathers were designated as Puerto Rican if Puerto Rico was their birthplace. This was done because of the importance of the Spanish culture and language in their family life. The Puerto Rican group, an ethnic rather than a racially differentiated population, includes Caucasians as well as Negroes. In regard to religious affiliation, 57 percent of the mothers interviewed were Catholic; 36 percent were Protestant; and 7 percent were Jewish.

Although the interviewers tried to see the mother of almost every child in the sample, except those who had surrendered the child for adoption or were inaccessible, they did not try to see every father. This was partly because in many cases the father, or his whereabouts, was unknown and partly in deference to ma-

ternal requests not to interview fathers who might react with consequences detrimental to the mother or child. Because so many fathers were not interviewed, the ethnic and religious distribution of the 137 fathers who were interviewed was slightly different from that of the mothers and included a somewhat higher percentage of Caucasians and lower percentages of Negroes and of Protestants.

Only 13 percent of all families in the study consisted of a mother, a father, and a child or children who all lived together before the child or children's placement in foster care. Fathers had been absent from two-thirds of the families for all or the greater part of the children's lives. Thirty-six percent of the mothers interviewed were single and had never married; another 36 percent were married but were not living with their spouses; and an additional 7 percent were divorced. Many of the mothers seemed to be repeating the family situations of their own childhood. While slightly over half the mothers (53 percent) had been raised by both of their own parents, 23 percent had been brought up by their mothers only, without a father in the home; 17 percent had been brought up by a person or persons other than their natural parents; 3 percent had been brought up by their fathers only; and 3 percent had been brought up in foster care. Information on the childhood of the remaining 1 percent was not obtained.

New York was the birthplace of 37 percent of the men and 37 percent of the women interviewed; and Puerto Rico, of 30 percent of each group. Twenty-four percent of interviewed mothers had been born in Southern States, but this was the case for only 17 percent of interviewed fathers. Mothers as a group were younger than fathers. About half of the women, but only a fourth of the men, were under 30 years of age at the time of the first interview.

## Socioeconomic conditions

Just before being placed in foster care, the majority of the children in the study were living in impoverished households located within the poorest neighborhoods of New York City. More than half the households in which the children were living before placement were located in the city's 14 neighborhoods having the highest juvenile delinquency rates and the lowest median family income. Many of the children were living in buildings containing health and safety hazards; among such hazards were rats, roaches, rotting floors, garbaged-littered halls, and inadequate light, ventilation, heat, or hot water.

**Shirley Jenkins**, left, and **Elaine Norman** are director and research associate, respectively, of the family study of the child welfare research program at the Columbia University School of Social Work, from which the data reported in their article were obtained. They are coauthors of a forthcoming book that is based on the full longitudinal research study.

More than half the families (52 percent) in which the children were living before placement were receiving some public assistance; and in about 45 percent, public assistance was the chief means of support. Wages or salaries were the primary means of support in 43 percent of the families; and income from sources other than salaries or public assistance, such as social security benefits or other insurance payments, alimony, or help from friends or relatives, in 8 percent. Among these families with earned income or insurance benefits, 7 percent were receiving supplementary public assistance payments.

Most of the families that were supported chiefly by public assistance had been receiving such assistance for many years, indicating patterns of chronic dependency. Forty percent had been receiving such help for 6 years or more; 11 percent for less than 1 year.

Among the families with wages or salaries, the weekly income was in most cases below the citywide average. Only 28 percent had total incomes of $100 a week or more. The median income of the salaried families fell between $75 and $99 a week, and in some cases the income reached this level only because supplementary public assistance was being received.

The research team developed a socioeconomic scale relevant to this impoverished group. The scale included five classifications: source of support graded by amount of income if salaried, or duration of public assistance if relevant; educational attainment of the best educated adult in the household; number of negative housing conditions; and rank of neighborhood among all city neighborhoods based on census data for income and juvenile delinquency. Within the sample, socioeconomic scores derived from this scale were assigned to each family, who were then grouped into high, middle, or low socioeconomic categories, according to their place on the scale. Thus, the terms "high" or "middle" socio-

economic status, as used in this report, refer only to the family's position relative to other families within the study group, and not in relation to any other population.

## Reason for placement

The single common denominator among all families in the study was that they had children in foster care. The reason for the children's placement away from home assumed major importance in the data analysis. Although reasons were noted on the case records at intake, the research staff undertook to delve deeper for the underlying reasons for placement, using the designation noted at intake, information in the case record after further investigation was made, the family interview, respondents' statements, and the judgments of social workers.

Although in nearly all cases the families had many unsettling problems, the factor that appeared to be most critical in the decision to place the child was recorded in the study data as the reason for placement. The reliability of these designations was tested by studying agreement among independent judges on the research staff. The findings showed the following reasons for placement:

- Mental illness of the child-caring person, determined either by professional diagnosis or the person's hospitalization, in 22 percent of the cases.
- Child behavior or personality problems, in 16 percent.
- Severe parental neglect or abuse of the child, 14 percent.
- Physical illness of the child-caring person, 11 percent.
- Unwillingness or inability to continue child care, 11 percent.
- Unwillingness or inability to assume child care, 8 percent.
- Abandonment or desertion, 8 percent.
- Other types of family dysfunction, 9 percent.
- Other reasons, 1 percent.

Differences in reason for placement were associated with the families' ethnic or religious backgrounds. White Jewish children, for example, were placed in foster care most often because of their own behavior; white Christian children (Protestant or Catholic) and Puerto Rican children (primarily Catholic) were placed most often because of the mental or physical illness of the child-caring person. A greater proportion of Negro children than of white or Puerto Rican children were placed in foster care because of parental neglect and abuse. These generalizations, however, do not apply to all cases; each ethnic and religious group included some children who were placed for nearly every reason listed.

Socioeconomic factors were also related to the child's entry into foster care. Children placed because of their behavior tended to come from families of higher socioeconomic levels. Children placed because of physical illness in the family tended to come from families of the middle or lower socioeconomic levels. Children placed because of neglect or abuse tended to come from families on the lowest socioeconomic level. Mental illness as a reason for placement, however, was evenly distributed among high, middle, and low socioeconomic groups.

In cases in which the main reason for placement was child behavior or mental or physical illness of the child-caring person, mothers tended to consider the placement of the child as having been "absolutely necessary." Where the reason for placement was neglect or abuse, abandonment or desertion, or family dysfunction, the mothers tended to see the placement as "not at all necessary." Where a medical agency or the school had first suggested the idea of placement, the mothers tended to see it as "absolutely necessary." When a complainer, the police, or the courts had initiated the action leading to placement, the mothers tended to see it as "not at all necessary."

## Filial deprivation

A major area of investigation in the study has been how parents felt the day their child was placed, one aspect of filial deprivation. A background discussion of this area of investigation has already been published in CHILDREN,[1] and some of the recent findings are being presented in another publication.[2] Therefore, only some highlights of the findings in this regard will be given here.

The parents were asked about 12 types of feeling: sadness; anger; bitterness; relief; thankfulness; worry; nervousness; guilt; paralysis; shame; emptiness; and numbness. Individual respondents reported having experienced from none to all 12 types of feeling on the day of placement. The mothers and fathers reported experiencing each of these types of feeling: sadness (87 percent of the mothers and 90

percent of the fathers); worry (76 percent and 68 percent); nervousness (68 percent and 56 percent); emptiness (60 percent and 42 percent); anger (45 percent and 50 percent); bitterness (43 percent and 43 percent); thankfulness (42 percent and 57 percent); relief (40 percent and 42 percent); guilt (39 percent and 30 percent); shame (36 percent and 39 percent); numbness (19 percent and 14 percent); paralysis (16 percent and 11 percent).

A significantly greater proportion of mothers of relatively higher socioeconomic circumstances reported being thankful and relieved upon placement than of mothers in the other socioeconomic groups. On the other hand, proportionately more mothers of relatively low socioeconomic circumstances reported being nervous and worried. The more mothers viewed placement as necessary, the more likely they were to have felt thankful and relieved on the day of placement and the less likely they were to have felt empty and worried. On the other hand, significantly more mothers who viewed the placement as not at all necessary felt angry, ashamed, and bitter.

The parents' feelings were significantly related to several reasons for placement. Thankfulness was significantly higher and guilt and anger lower among families whose children had been placed because of physical illness of the mother. In families whose children had been placed because of behavior problems both guilt and relief were significantly higher and anger and bitterness significantly lower. Anger was significantly more frequent among mothers whose children had entered foster care because of severe parental neglect or abuse, or family dysfunction.

## Parental attitudes

In addition to inquiring into the parents' feelings at a time of intense crisis, the study looked into the parents' general social orientation and their attitudes toward child-caring agencies and child-rearing methods and goals.

***Social orientation.*** The parents' attitudes toward life in general were studied to gain an understanding of the family's social orientation. The interview instrument included 15 items intended to identify attitudes of alienation, trust, and calculation. The items used for studying alienation were developed by Srole;[3] those used in relation to trust and calculation were developed by Struening and Richardson.[4]

Preliminary inspection of the responses indicates that, on the whole, the parents of children placed in foster care see the world primarily from a calculating and alienated point of view. Of all items, the one with which the greatest number of respondents (89 percent of the mothers and 96 percent of the fathers) agreed was: "A man should be allowed to make as much money as he can." The item achieving the next highest level of agreement (85 percent of the mothers and 88 percent of the fathers) was: "In a society where almost everyone is out for himself, people soon come to distrust each other." Conversely, the item with the lowest level of agreement was: "Most people can be trusted."

On the basis of the Srole anomie scale,[3] Puerto Rican mothers and fathers of children in the sample were found to be significantly more alienated than either the white or the Negro parents. With regard to feelings, significantly more mothers who had an alienated social orientation felt anger at the time of the placement. On the other hand, significantly more mothers whose social orientation was generally trusting had felt shame.

***Attitudes toward agencies.*** The interview instrument also included items relevant to the attitudes of parents toward child-care agencies. These items were used to identify three mutually exclusive types of perception of child-caring agencies: as facilitators, as usurpers, and as surrogates. The great majority of the mothers and fathers saw agencies as facilitators of care, agreeing with the statement: "It's a good thing that there are institutions and foster mothers to do the job when a real mother is not able to take care of her child." However, about 15 percent of the parents saw the agencies as usurpers, agreeing with the statement: "Agencies act like parents have no rights at all—they think they own the children." A few parents—7 percent—saw agencies as surrogates acting *in locus parentis.*

Those mothers and fathers who were at the lower socioeconomic levels were more likely to view child-care agencies as usurpers or surrogates. Protestant Negro parents were the most likely of all groups to view agencies as usurpers, whereas Puerto Rican parents were the most likely to see agencies as parent surrogates. Parents whose children had been removed from their homes because of neglect or abuse were more likely to regard the child-care agency as a usurper of parental rights. Mothers who saw agencies as usurpers were more likely to feel angry and ashamed on the day of placement.

***Child-rearing attitudes.*** With the hypothesis that attitudes would be related to family characteristics,

the investigation gathered data on parental attitudes in child rearing, especially in relation to the permissive-authoritarian spectrum. The interviewers used six sets of paired items developed by Loevinger,[5] each representing socially acceptable parental behavior. The findings showed that two-thirds of the parents of the children in the sample had strongly authoritarian attitudes in response to such behavior as hitting, crying, lying, and talking back. Parents of higher socioeconomic levels tended to be more permissive, as did white Jewish mothers and fathers. Authoritarian attitudes predominated among Protestant Negro parents but not among Catholic Negro parents.

***Preferred child traits.*** The parents were also asked what traits they considered to be most important for a 10-year-old child to have. Each respondent was asked to choose three traits from seven included on a checklist developed by Kohn.[6] The traits most frequently chosen by both mothers and fathers were "honest," "obedient," and "neat and clean." The traits least frequently chosen were "self-controlled," "considerate," and "dependable."

A larger proportion of parents at the higher socioeconomic level chose "happy," "considerate," and "self-controlled" than at the other socioeconomic levels. Parents at the middle socioeconomic level most often chose "honest," "dependable," and "obedient." Mothers and fathers at the low socioeconomic level chose "neat and clean" as a desirable child trait with far greater frequency than parents at the middle or high levels.

## Investment and aspirations

Several open-ended sentences were included in the interview to explore the emotional investment in the child on the part of each parent. Both mothers and fathers were asked to complete seven incomplete sentences, such as: "For a mother a child is . . ." and "For a father a child is . . . ." An analysis of their spontaneous responses could be classified into five categories, which described children as a burden; as a source of happiness; as a value—"a source of pride"; as an investment—"a reason to exist"; and as a relationship—"love."

About one-third of the mothers and the fathers saw the child as an "investment," and one-fourth saw the child as a "value." Mothers and fathers tended to misjudge and negate each other's feeling for a child. Thus, although only 5 percent of the mothers regarded the child as a burden to themselves, 10 percent of the fathers said a child was a burden to a mother. Similarly, while only 9 percent of the fathers regarded a child as a burden to themselves, 17 percent of the mothers saw a child as a burden to a father. Mothers found it more difficult to empathize with fathers than fathers with mothers. Only 4 percent of the fathers said they could not complete the sentence, "For a mother a child is . . .," but 21 percent of the mothers could not complete the comparable sentence, "For a father a child is . . . ."

To assess aspirations, each parent was asked, "If you had three wishes, what would they be?" Although interviewed separately—and more often than not, living apart—mothers and fathers expressed wishes that closely corresponded. The wishes mentioned by approximately half of the mothers and half of the fathers were, "to have my child back," and "to have a home with my family all living together." Other wishes frequently mentioned were for mental or physical health, to have or to find a good spouse, to get a good job, to earn money, to get "off welfare," to find happiness.

For parents to wish for a satisfying family life and for financial security might be expected. For most parents such wishes might even be interpreted as oriented to reality. However, a review of the study findings, including the data on family breakdown, illness, and impoverishment, may lead to a different interpretation here. What may be a reality-based wish for some parents may be only an expression of fantasy for families with children in foster care.

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an essay review . . .

# of dreams and reality : KIBBUTZ CHILDREN

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Family structure and child-rearing procedures in the kibbutzim, the communal settlements in Israel, have intrigued Western investigators for some time, although less than 5 percent of all Israeli children are being reared in kibbutzim. In a kibbutz, the good of the entire community and complete equality of rights and status for all who compose it are primary values. Private property does not exist. Neither does the family in its traditional sense as a setting for child rearing.

From infancy to maturity, kibbutz children are reared in children's houses with other children of their own age. The biological mother is intensively involved in caring for the infant during the first few months of life, but afterward the main responsibilities for the child's training and socialization up to the period of puberty are given to the housemother, or metapelet. From the start, although the child visits with his parents and biological brothers and sisters for a few hours every day and for longer periods on weekends and holidays, the main center of his life is the children's house. His peer group provides a constant social environment, presided over by the housemother who is joined by teachers and youth leaders as the child grows older.

The cardinal purpose of the founders of the kibbutzim in establishing these child-rearing procedures was to create a new personality or "new man" who could easily adjust to communal living. In his new book, "The Children of the Dream,"* Bruno Bettelheim attempts to penetrate into this personality of the "new man" and learn to what extent the dream of the founders of the kibbutzim has been realized. By frequent comparisons between education in a kibbutz and in America, Bettelheim also tried to glean some ideas and principles that may be transferred from the kibbutz experience to the American scene.

Much of what Bettelheim has to say is consonant with the findings of systematic studies of the kibbutz published some years ago.[1-4] Among the chief "good" findings concerning the members of the second generation of the kibbutzim is an absence of delinquency and of severe psychopathology in the form of schizophrenia, an absence of inner conflict in the kibbutz personality, a devotion to community and country, an effectiveness in teamwork and interpersonal relations, and a general readiness to continue in the collective form of life. On the negative side of the ledger, Bettelheim points to a severe repression of sexuality in adolescence and an emotional distance between the kibbutz child and others—whether parents or peers—that Spiro has called introversion.[1] Bettelheim also sees the second generation of children of the kibbutzim as lacking a capacity for intimacy and exhibiting only average ability and achievement because of a "leveling impact."

## Some differing opinions

The author agrees with my own earlier investigation concerning the psychodynamic and intrapsychic processes that underlie the kibbutz personality.[3-6] We have both noted the low intensity of the Oedipal relationships, the diffuseness of identification in superego formation, and the relative simplicity of the psychic defensive structure. However, Bettelheim makes some additional observations, speculations, and conclusions with which I must take issue.

1. ***The leveling effect.*** One of the first speculations social scientists usually make about the kibbutzim is that their child-rearing methods must produce some kind of homogenized child. Bettelheim is caught up in a similar conjecture. In support of the contention that the kibbutz educational system has this leveling effect, he cites without identifying a "nationwide study of scholastic achievement" in Israel. In this study kibbutz adolescents ranked second in achievement tests—next to students of standard Israeli urban high schools. In the kibbutz group, 30 percent scored above 75; 32 percent, from 64 to 75; and 38 percent, less than 64. But only 24 percent of the young people from a rural cooperative settlement (moshav) scored above 75; 23 percent from 64 to 75; and 53 percent, less than 64. Thus, there is no question as to the superiority of the kibbutz youngster when compared with other rural youngsters on the achievement tests. However, Bettelheim makes a further breakdown of the high-scoring groups, noting that 2.3 percent of the nonkibbutz rural group scored 85 or above, compared with 2.1 percent of the kibbutz group.

*Bettelheim, Bruno: The Children of the Dream. The Macmillan Company, 866 Third Ave., New York, N.Y. 10022. 1969. 363 pp. $6.95.

He cites these figures, which are probably not significant statistically, as evidence of the "leveling effect" on kibbutz children. Moreover, he disregards the possibility that the achievement tests are geared to a more conventional curriculum than the curriculum of the kibbutz schools.

From the evidence offered, it is doubtful that "the leveling influence seems to have reduced to a respectable middle level those students who had a potential to be top performers." The varied imaginative productions reported from the kibbutz school [3] hardly lend support to such a conclusion. To be sure, kibbutz education is not competitive nor achievement oriented, yet it is remarkable that it produced the second highest level among the groups studied nationally.

2. ***The kibbutz product.*** An attempt is made in this book to explode "the legend . . . that kibbutz-educated youngsters make the best soldiers." Bettelheim admits that soldiers from kibbutzim have a great *esprit de corps* and great readiness to make the supreme sacrifice. He does not question their courage, but he cites the high casualty rate of soldiers raised in kibbutzim and quotes an officer to support his belief that they are not flexible enough to make the complex decisions necessary to survive in war. He does not consider that the high casualty rate may be due to the fact that many kibbutz youngsters become paratroopers, pilots, or officers. Such roles of leadership and skill often demand flexibility and capability for complex decisions, which the kibbutz-reared young men have amply demonstrated.

3. ***The problem of intimacy.*** According to Bettelheim, the kibbutz child does not develop the capacity for intimate relationships because he does not have a close relationship with any one person. He tends to relate to many people, but in a superficial and impersonal manner. It seems to Bettelheim that "a child who has lived a life of equality receives no vast surplus of . . . dependent intimacy, and without it he cannot later afford to give it to others." Living with the group, the child "fails to live intimately with any one of them."

It may seem reasonable to assume that the kibbutz child lacks an intimate relationship with peers and adults. However, examination of some post-humously published diaries of kibbutz adolescents and my own close observation of the interaction between some parents and children suggest the contrary. The fact is that kibbutz young men and women fall in love, get married, and develop close relationships with other men and women. There is a difference between intimacy and emotional closeness on the one hand and between demonstrativeness on the other. The kibbutz youngsters are trained to shun public demonstrations of affection, but this does not necessarily betray a lack of capacity for close relationships.

4. ***Repression of sexuality.*** Bettelheim contends that since sexuality of kibbutz adolescents is inhibited by the demands of kibbutz morality, especially under the heightened stimulation of mixed sleeping quarters, the "repression" generalizes to the entire personality and affects later capacities, including mature sexual love and intimacy. Moreover, he states that this repression "drains" the energies of kibbutz adolescents.

I doubt whether repression is the process; it is more likely conscious *suppression.* Evidence shows that once a kibbutz youngster enters the army, his inhibitions do not persist.[3,5] They do not prevent him from heterosexual love, marriage, and procreation. Again, although the young person in the kibbutz is not as demonstrative as is the American college sophomore, his sexuality is not any less mature. The absence of homosexuality in the kibbutz setting is additional evidence that heterosexual drives are temporarily suppressed rather than pathologically repressed. Bettelheim's findings of "endemic fatigue" in the kibbutz adolescent are based on personal observation not readily validated.

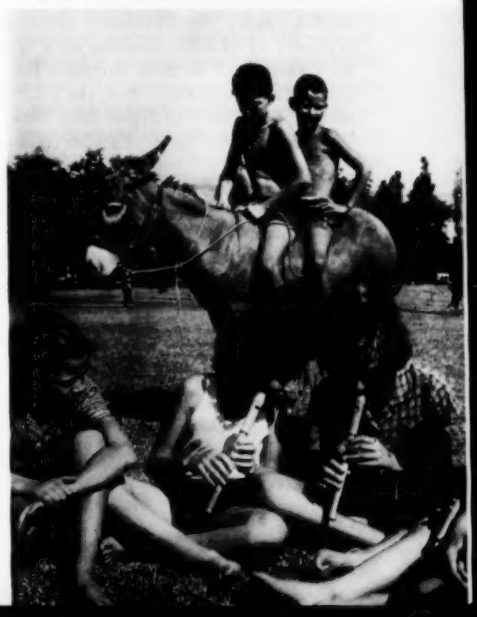
5. ***Emotional flatness.*** Bettelheim reports his impression of the "emotional flatness" of the second generation in the kibbutz. He maintains that there is no "depth" in the emotions of such young people. It may be, however, that the casual observer cannot fathom the depth in his interaction with persons who on the whole tend to be shy. Bettelheim says, "[I] failed to evoke any such depth in the younger generation, though I found it often enough in the founding generation and in those who were kibbutz-born but had left." This is a rather curious comment, for it implies that kibbutz-born youngsters are capable of achieving emotional depth if they leave the kibbutz but not if they remain.

## Other issues

Two more issues, one of theoretical and the other of practical import, are worthy of consideration. The first concerns the structure of the psyche of the kibbutz-born person. Bettelheim regards the superego of the kibbutz child as a "collective superego." Since the child does not introject the standards of his parents because of the distance of his relationship with them, he adopts instead the collective conscience of the peer group. In this instance, the superego is close to the external reality itself—the demands of the group. Yet the conscience of the kibbutz child operates in the absence of the group, just as the conscience of the Western child controls his behavior in the absence of the parents who are responsible for its genesis.

Bettelheim calls the kibbutz youngster's conscience a simplified superego, since no internal dialogue created by the internalization of conflicting standards of parental figures takes place. One might ask whether introjection of group standards does not involve the introjection of the standards of individual members of the group. The child in the kibbutz introjects standards of parents as well as of the housemothers or meta-

**A moment of music and relaxation among a group of adolescents in a kibbutz.**



plot, who do not always agree on a "monolithic" kibbutz ideology. Therefore, the possibility of complexity in the kibbutz child's superego should not be ruled out. However, the notion of a "collective superego" is worthy of further detailed study.

The issue of practical import is the possibility of applying child-rearing principles of the kibbutzim in our own society. Suggestions are being made today for a reconsideration of the possibilities of child rearing in institutional settings, after a long period of widespread opposition to institutional placement of children. I have suggested that we might consider the use of well-staffed and well-directed institutions for many young children and even infants who are in overpopulated, neglected, and often disorganized family settings in slum and poverty areas. As I explained to the Wisconsin Psychiatric Association, "Multiple mothering in stimulating institutional environments may well be preferable to 'continuous' mother-child relationships when the mother is inadequate, retarded or disturbed, and a father is absent permanently or intermittently, and where the setting is that of poverty and extreme cultural deprivation." [6]

Bettelheim agrees directly and implicitly with these ideas. However, the implementation of such programs would be a highly complex, difficult undertaking. Finding parents who would be willing to be separated from their children and finding the equivalent of good metaplot for such institutions could be major obstacles. Nevertheless, recognition of the desirability of having institutions may be an important first step to innovative planning.

A great many other practical and theoretical issues could be discussed, for the author deals with a variety of topics in a thought-provoking manner. However, the book suffers from a number of handicaps under which the author labored—the brevity of his time in Israel, a language barrier, and a tendency to draw generalizations from episodic material. Moreover, by neglecting the indigenous Israeli culture and by comparing the evolving kibbutz personality with a semblance of a Western "national character," he tended to consider some characteristics to be "uniques" to the kibbutz, when, in fact, they may be part of the total rural society of Israel.

Despite these handicaps, Bettelheim has produced a highly stimulating and theoretically sophisticated work. "The Children of the Dream" may serve as a rich source of hypotheses for future systematic investigations into personality development in the kibbutz.

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# British publications

THE DEVELOPMENTAL PROGRESS OF INFANTS AND YOUNG CHILDREN. Mary D. Sheridan. British Ministry of Health. Reports on Public Health and Medical Subjects No. 102. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 11 pp. 50 cents.

Briefly describes the normal behavior patterns of infants and young children at different ages between 1 month and 5 years—posture and large movements, vision and fine movements, hearing and speech, and social behavior and play.

SOCIAL WORK IN CHILD CARE. Elisabeth Pugh. Routledge & Regan Paul Ltd., London, England. U.S. distributor: Humanities Press, 303 Park Ave. South, New York, N.Y. 10010. 1968. 118 pp. $1.50.

Examines major aspects of child care services in a local public agency in the United Kingdom, including preventive work with parents and children at home, reception into care, the child in care and his family, foster care, residential care, adoption, and the children's department itself.

BLIND AND PARTIALLY SIGHTED CHILDREN. Shirley R. Fine. Department of Education and Science, London, England. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 43 pp. $1.20.

Reports the findings of a survey of 2,191 children in special schools and classes for the blind and partially sighted in England and Wales, conducted between 1962 and 1965. Includes data on clinical diagnosis, etiology, visual acuity and fields, previous schooling, mobility, intelligence, additional handicaps, mannerisms, teaching methods, use of visual aids, and attitudes of children, parents, and teachers.

BEGONE DULL CARE: an informal guide to residential care of children. Ben Vincent. Advisory Council on Child Care, Home Office, London, England. U.S. distributor: British Information Services, 845 Third Ave., New York, N.Y. 10022. 1968. 102 pp. $2.50.

Advises institutional houseparents on ways of dealing with new groups of children and their parents, transfers, housekeeping, visitors, school, the teenager, smoking, telling the truth, feelings of failure, television, and other aspects of the houseparent's daily routine.

# HERE and THERE

## Courts and AFDC

Durational residency requirements for persons seeking public assistance were declared unconstitutional by the Supreme Court of the United States on April 21, 1969. The Court, in a 6-to-3 decision, ruled that the 1-year waiting period required of persons coming into Connecticut, Pennsylvania, and the District of Columbia has the "purpose of inhibiting migration by needy persons into the State" and is, therefore, "constitutionally impermissible."

As a result of the ruling, Secretary of Health, Education, and Welfare Robert H. Finch on June 3 issued regulations that prohibit States from imposing durational residency requirements as a condition of eligibility for public assistance under public assistance titles of the Social Security Act. The regulations cover all Federal-State public assistance programs including aid to families with dependent children (AFDC).

At the time of the ruling, 39 States and the District of Columbia had durational residency requirements for applicants seeking assistance under the AFDC program. Because of pending court cases, such requirements had been suspended in seven States and the District of Columbia in some instances for more than a year before the Supreme Court ruling.

The Court reaffirmed the appellate courts' rulings that "the nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement." In the decision, known as *Shapiro* v. *Thompson*, the Court pointed out that "the prohibition of benefits to residents of less than a year creates a classification which constitutes an invidious discrimination denying them equal protection of the laws."

"A State may no more try to fence out those indigents who seek higher welfare benefits than it may try to fence out indigents generally," the decision stated. ". . . we do not perceive why a mother who is seeking to make a new life for herself and her children should be regarded as less deserving because she considers . . . the level of a State's public assistance. Surely such a mother is no less deserving than a mother who moves into a particular State in order to take advantage of its better educational facilities."

Officials in the Department of Health, Education, and Welfare have estimated that the ruling could add 100,000 to 200,000 people to various programs of public assistance, at an increased cost of between $140 million and $200 million a year to Federal, State, and local governments. At present, the Federal Government pays about 55 percent of the cost for assistance programs.

. . .

Maine's regulations setting maximum family grants for recipients of aid to families with dependent children (AFDC) were declared "void and unenforceable" by a three-judge Federal District Court for the Southern Division of the District of Maine on March 21, 1969. In the case of *Westberry* v. *Fisher*, the court ruled that the Maine State Department of Health and Welfare discriminated against large families in violation of the equal protection clause of the 14th amendment, by limiting AFDC grants to families to $250 and by limiting family budgets—or total income from all sources for families receiving AFDC—to $300.

Pointing out that the State is "free to take reasonable steps" to allocate its resources available for AFDC on a nondiscriminatory basis, the court stated: "We are aware that the impact of our decision upon the State's AFDC program, in the absence of an additional appropriation, may mean some reduction in the amounts of grants to many present recipients." It noted that seven States have regulations providing percentage reductions or similar nondiscriminatory methods for limiting standards of need or grants.

The court also noted that the State's maximum grant regulation created "a class of needy children who receive a lesser amount of public assistance than do other children who are in all respects similarly situated, except that they live in smaller families."

## Youth participation

At its annual meeting in New York City May 1–2, the National Assembly for Social Policy and Development, Inc., added six young people under 20 years of age and three young adults between 20 and 26 to the 300 older persons who compose its trustee membership. By this action, the Assembly fulfilled one of the 130 recommendations of a youth-adult Dialogue of Ages, which took up a full day of the annual meeting.

The "dialogue" brought together 99 young people representing a broad spectrum of backgrounds from all sections of the United States and 152 adults who are members of the National Assembly, either as individuals or representatives of organizations. Groups of 10, composed of both young people and adults, probed the following issues of mutual concern to the younger and older generations: the sharing of power, the emergence of autonomous youth organizations, collaboration of young people and adults on problems of social control, establishment of trust between generations, young people as volunteers, the world of work, educational experience for intergenerational collaboration, and emergence of new sex roles and family patterns.

Differences in values, described as a "people gap," rather than the difference in chronological age, or "generation gap," were frequently cited to explain misunderstandings between young people and adults. One of the value differences noted was in the sense of urgency

about resolving the social lags representing poverty and racial discrimination. As one teenage participant put it, "We want to do something about the problems *now*."

One recommendation called for establishment of local and national youth task forces to study the role of young people in bringing about social change. Among other recommendations were those urging the National Assembly and other groups to use their influence to see that—

- The voting age be lowered to 18.
- Young people be allowed to participate in decisions that affect their lives, as well as in decisions bearing on societal and environmental conditions—in such ways as being given an equal role with adults in designing and carrying out policies in regard to high school and college curriculums, faculty selection, and budgeting; and serving with adults on draft boards.
- Economic, medical, and educational support be provided to each needy family on a level and in a manner that insures human dignity.
- Minimum and maximum age requirements for jobs be eliminated and eligibility be determined by ability and qualifications.
- Free education be made available from kindergarten through college, through Federal funding of the educational system.
- Age requirements for all elective offices be lowered.
- Adults and youth work together in developing educational programs to serve the community's needs.
- National programs of adequate income maintenance be established.
- Artificial barriers between school and work be removed to provide students an opportunity to move freely from school to work and vice versa.

The recommendations will be studied during the next year by a task force that includes young people as full participants and by Assembly members at regional conferences.

## New publications

The first issue of *Day Care Notes*, published by the Children's Bureau on behalf of the Federal Panel on Early Childhood, came off the press in April. Designed to bring information about new Federal programs, policy changes, and other current activities to persons in the field of day care, *Notes* will appear from time to time on an irregular schedule. *Day Care Notes* is distributed in bulk to national, regional, State, and local governmental and voluntary agencies and organizations concerned with day care.

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*Sharing*, a newsletter designed to present information about comprehensive service programs for schoolage pregnant girls, was launched recently by the Cyesis (Pregnancy) Programs Consortium of Yale University and the University of Pittsburgh, with support from the Children's Bureau. It carries reports of workshops for persons who work in such programs, book reviews, abstracts of articles, and reports of current programs and other items. Copies may be obtained from the editor, Marion Howard, Room 406, 715 G Street NW., Washington, D.C. 20001, as long as supplies last.

## Child development

The adequacy of measures now being used to test the achievement potential of bilingual children is challenged by a study conducted at the University of California at Los Angeles by Tom Hickey, a doctoral candidate in the Division of Behavioral Sciences. The study of 320 Head Start children in Los Angeles County, Calif., indicated that the Peabody Picture Vocabulary Test (PPVT), which has been used by Project Head Start to measure verbal learning ability since 1965, presents special problems of comprehension to the bilingual child whose primary language is Spanish.

In the study Caucasian children between 3.5 and 5.6 years of age who speak only English had little trouble identifying pictures representing such verbal nouns as falling, hitting, and climbing; in contrast, bilingual Mexican-American children of the same age often were baffled by pictures of a language form that is not found in Spanish.

The investigator accepted the validity of the PPVT for measuring the verbal learning ability of young English-speaking children, including those who are handicapped, retarded, or culturally deprived. On the basis of his findings, however, he questioned the value of using the PPVT to predict scholastic achievement of Mexican-American children, who are not members of the cultural group upon which the test was standardized.

For the study, raw scores obtained by giving the PPVT to 100 Caucasian boys and girls whose average chronological age was 4.6 years and 100 Mexican-American boys and girls whose average chronological age was 4.8 years were converted to mental age equivalents. The median mental age of the Caucasian children, 3.8 years, was significantly higher than the corresponding median mental age, 3.2 years, of the slightly older Mexican-American children. This difference practically disappeared when the scores were adjusted to exclude items that involved verbal nouns (about 20 percent of the PPVT pictures). On the adjusted tests, the median mental ages rose to 4.0 years for the Caucasian children and 3.9 years for the Mexican-Americans.

A second part of the study, in which no verbal nouns were used, registered identical median mental ages of 4.2 years for 60 Caucasian and 60 Mexican-American boys and girls, although the median chronological age of 4.7 years of the Caucasians was 0.1 of a year less than that of the Mexican-Americans.

All the children in the study were from families receiving public assistance. On the basis of his findings, Mr. Hickey suggests that Mexican-American preschool children be evaluated by other instruments and methods, or—if the PPVT test is used—that the programmed error be recognized and necessary interpretations made.

## Child health

Children with cleft palates who do not speak clearly although they are able to close off the nasal passages may need psychological help to improve their poor speech patterns, investigators conducting long-range interdisciplinary studies in cleft palate at the University of Pittsburgh School of Dentistry have suggested.

The investigators, Betty Jane McWilliams and R. H. Musgrave, M.D., working at the university's Cleft Palate Research Center under a grant from the National Institute of Dental Research, have analyzed the speech and behavioral problems of 170 children with cleft palates. The children, who were between 3 and 10 years of age, were divided into three study groups. The first

group consisted of 32 children with essentially normal speech. The second group included 77 children who were able to close off the nasal passages by action of the soft palate, but who made errors in articulation of consonants that could not be explained on the basis of physical limitations. The third group of 61 children spoke nasally, making errors in articulation characteristic of incomplete palatal closure.

The investigators found that children in the second group, who made errors in articulation but whose voices were not nasal, seemed to have the necessary palatal mechanisms for good speech. These children showed greater emotional disturbances, reflected in bad temper and bed wetting, than children in either of the other groups. The investigators concluded that the poor speech of children in the second group is likely to be the result of psychological, not physiological, factors.

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The number of deaths due to accidental poisoning of children under 5 years of age reached a 25-year low of 345 in 1966, according to the National Center for Health Statistics, although the number of deaths from accidental poisoning in the total population increased during the same period.

Reports to the National Clearinghouse for Poison Control Centers show that in 1966 aspirin and salicylates caused 92 of the 155 deaths from drugs in young children; lead and lead compounds, 38; petroleum products, 35; corrosive aromatics, acids, and caustic alkalies, 10; and other solid and liquid substances, 72.

Estimates based on the Health Interview Survey, carried out by the National Center for Health Statistics during the 1967 fiscal year, indicate that accidental poisonings occurred among 384,000 children under 6—a rate of 16 for every 1,000 in the age group.

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Accidental deaths in 1968 decreased by 8 percent among children under 5 from the number in 1967, but sharply increased among older children and young people, according to figures compiled by the National Safety Council. The 8,700 accidental deaths among children from 5 through 14 years of age in 1968 represented a 12-percent increase; the 23,300 accidental deaths among young people between the ages of 15 and 24, a 9-percent increase. Part of these increases is attributable to a 2,000 rise in deaths from motor vehicle accidents among persons between the ages of 5 and 24.

## Mental health

Admission rates for children under 18 years of age to both outpatient and inpatient psychiatric facilities in the United States almost doubled in the 8 years before 1967, according to the findings of a study recently completed by the National Institute of Mental Health. The study found that in 1966 about 473,300 children under 18 years received some service at a psychiatric facility. However, it concluded that, on the basis of estimates from three surveys of school children needing psychiatric care in Los Angeles, Chicago, and Georgia, about 1,400,000 children in this country were in need of such care during that year.

Of the estimated 473,300 children who received service, 84 percent were seen at outpatient psychiatric clinics; 14 percent were in public or private mental hospitals or general hospitals; 2 percent were in residential treatment centers; and less than 1 percent were in psychiatric day-care programs.

Two-thirds of the children seen at outpatient psychiatric clinics were 10 to 17 years of age, while over 50 percent of the children seen in psychiatric day-care programs were in this age group. In inpatient facilities, 10- to 17-year-olds accounted for from 76 to 95 percent of the children seen—76 percent in general hospitals, 89 percent in public mental hospitals, and 95 percent in private mental hospitals.

About 65 percent, or 300,000, of all the children who received psychiatric care were boys. In all the facilities except general hospitals, there were relatively more boys than girls with diagnoses of "personality disorder" and relatively more girls than boys with diagnoses of "psychoneurotic disorder." Brain syndromes and mental deficiency were more frequently diagnosed among children under 10 years of age than among older children. Psychotic disorders—in particular, schizophrenic reactions, psychoneurotic disorders, and personality disorders—were more frequent among children 10 to 17 years of age.

The study also found that mental health resources for children in rural areas are few in number, although the number of mental health clinics throughout the country has increased substantially—owing in large part to Federal support under the National Mental Health Act of 1946. For example, of the 2,007 clinics open in 1965, only 234 located in rural areas served children.

It is estimated that if the child population continues to grow at its present rate, by 1975 there will be over 77½ million children under 18, of which 1½ million will need psychiatric help.

These and other data are included in the study report, "Utilization of Psychiatric Facilities by Children: Current Status, Trends, Implications," by Beatrice M. Rosen, Morton Kramer, Richard W. Redick, and Shirley G. Willner, available from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402. (Price: 75 cents.)

## Maternity care

In the first 3 years after the inception of a maternity and infant care project at the University of Nebraska, Omaha, the number of women reporting at the hospital for delivery without having had any prenatal care dropped from 12 percent to 6.5 percent, according to Marion Slatin, the project's chief nurse.

The project, which is supported by the Children's Bureau, provides free prenatal care to women of low income or at high risk of suffering a pregnancy casualty. The care includes laboratory work, X-rays, physical examination, dental care, medications, and instructions and other counseling.

To find ways of making the project effective in attracting women to prenatal care, the chief nurse held postpartum interviews at the hospital in 1965 with 64 of the 85 women who delivered there that year having had no such care. Nineteen gave no reason for not seeking prenatal care or said they felt it was not important; 45 gave specific reasons such as lack of a babysitter (9), money problems (8), inability to get away from work (6), newness in the community (6), transportation

difficulties (3), fear of examination (3), and other problems (10).

As a result of the interviews, the project hired a babysitter to care for patients' children in a playroom at the prenatal clinic. It chartered a bus to carry the mothers from their neighborhoods to the clinic, but because only a few patients used the service, it later substituted the provision of taxi or bus fare for mothers with transportation problems, a less expensive method. It also opened two satellite clinics in the neighborhoods where the patients live, using the same staff members who operate the maternity clinic at the hospital.

Interviews conducted with 16 of the 18 mothers delivered at the hospital between June and October 1968 without having had prenatal care revealed that unfamiliarity with community resources because of the recentness of arrival was now the chief barrier to the receipt of prenatal care; 6 of the 16 mothers cited newness to the community as the reason they had not had such care. Five mothers gave no reason; two cited fears; and three cited premature deliveries or plans to move from the city.

## Rubella vaccine

The Department of Health, Education, and Welfare on June 10 issued the first U.S. license for a live attenuated rubella (German measles) vaccine to Merck Sharp & Dohme, West Point, Pa. The vaccine, which uses the HPV–77 rubella virus strain developed by scientists at the National Institutes of Health, has been given to more than 18,000 children and adults in community testing in this country and abroad in the past 2 years.

The Public Health Service Advisory Committee on Immunization Practices recommended in May that the vaccine "should be given to boys and girls between the age of 1 year and puberty. No pregnant woman should be given the vaccine and immunization of adolescent girls and adult women should not be undertaken routinely."

# guides and reports

ONE-PARENT FAMILY: perspectives and annotated bibliography. Benjamin Schlesinger. University of Toronto Press, Toronto 5, Ontario, Canada. 1969. 132 pp. $5.

Contains three papers on problems and types of one-parent families and research considerations in regard to them in addition to the bibliography.

ALCOHOLISM AND FAMILY CASEWORK: theory and practice. Margaret B. Bailey. Community Council of Greater New York, 225 Park Ave. South, New York, N.Y. 10003. 1968. 162 pp. $3.

Presents the contents of a training course on the nature and treatment of alcoholism developed for the casework staff of three New York family service agencies.

LEARNING TO APPLY NEW CONCEPTS TO CASEWORK PRACTICE: a staff development seminar. Edited by Gertrude Einstein. Family Service Association of America, 44 East 23d St., New York, N.Y. 10010. 1968. 135 pp. $6.25.

Contains the theoretical papers, case presentations, and staff discussions of an inservice training program focused on crisis intervention, the application of role theory and systems theory, and family group diagnosis and treatment.

LIVING WITH CHILDREN: new methods for parents and teachers. Gerald R. Patterson and M. Elizabeth Gullion. Research Press, Box 2459, Station A, Champaign, Ill. 61820. 1968. 120 pp. $2.50.

In a programed form of instruction, presents a method of encouraging desirable behavior and eliminating undesirable behavior in children; a guide for professionals in using the booklet with parents is available.

VOLUNTEERS LOOK AT CORRECTIONS: report of a survey. Joint Commission on Correctional Manpower and Training, 1522 K St., NW., Washington, D.C. 20005. 1969. 30 pp. $1.

Reports on the findings of a national survey of 541 volunteers working in correctional institutions, probation and parole agencies, and volunteer courts for juveniles and adults—their characteristics and their attitudes toward and involvement with the agencies.

CHILD PROTECTIVE SERVICES AND THE LAW. Thomas T. Becker. Children's Division, The American Humane Association, P.O. Box 1266, Denver, Colo. 80201. 1969. 24 pp. 35 cents.

Examines the possible impact on neglect proceedings of two recent decisions of the Supreme Court of the United States requiring due process of law in juvenile delinquency proceedings, those handed down in the Gault and Kent cases.

NUTRITION AND INTELLECTUAL GROWTH IN CHILDREN. The Association for Childhood Education International, 3615 Wisconsin Ave., NW., Washington, D.C. 1969. 63 pp. $1.25.

Presents papers on such subjects as hunger in America, nutrition and intellectual development in children, maternal diet, growth and behavior, and the role of the school in providing for nutrition.

THE TEENAGER AND VD: a social symptom of our times. Celia S. Deschin. Richards Rosen Press, Inc., 29 East 21st St., New York, N.Y. 10010. 1969. 130 pp. $4.

Discusses the nature of venereal diseases, the problems of rising incidence among adolescents and their relation to the changing social climate; and includes a list of audio-visual aids.

# BOOK NOTES

THE MULTI-PROBLEM DILEMMA: a social research demonstration with multi-problem families. Edited by Gordon E. Brown. Scarecrow Press, Metuchen, N.J. 1968. 189 pp. $5.

This book presents the "case history of a research project that produced . . . an unsettling result." The objective of the project, which has come to be known as "the Chemung County study," was to assess the effects of intensive social casework with 50 "multi-problem" public assistance families, as compared with the effects of "normal public assistance services" given to 50 similar families. The conclusion was that "while the demonstration group attained a slightly better degree of family functioning, its margin or progress over the control group was not significant in the statistical sense."

The book includes a history and report of the study itself and commentaries on its implications for social work education, the practice of social casework, research in social work, and social policy regarding the kinds of families involved. Included also are excerpts from a seminar discussion of the study and the commentaries by "knowledgeable, experienced, thoughtful and articulate" participants.

In the course of the papers and the discussion, few criticisms are leveled at the research techniques of the study. More attention is given to some widespread assumptions about the social casework, especially its ability to substitute for the meeting of subsistence needs; the characteristics and needs of "multi-problem" families; and the need for realism and clarity about problems to be attacked, changes to be effected, and appropriate targets of change. Several recurrent themes of the seminar converge in Helen Harris Perlman's summary comment that "what casework can and cannot be expected to do must be thought out and spoken out. And along with this we must come to grips with what changes or shifts in our theory stance and practice operations may be necessary if we are to fit our actions to the special characteristics of special groups of people."

THE NON-VERBAL METHOD IN WORKING WITH GROUPS. Ruth R. Middleman. Association Press, New York, N.Y. 1968. 285 pp. $6.95.

Nonverbal communication can be used in the practice of social group work to help both the group and the individuals in it gain new insights and skills, according to the author of this book. A social work educator and consultant in group work to social agencies, she maintains that creative use of nonverbal forms of program activities is a skill that can be mastered by any thoughtful persistent practitioner.

In an activity program, "the primary method of communicating begins with and is related to some kind of action," the author explains. She tells how to analyze the values of nonverbal content of such programs, presents an analysis form for identifying patterns, and gives a number of exercises using the analysis form.

The use of nonverbal activities to achieve specific groupwork goals is illustrated by 80 case vignettes taken from groups of all ages, although more than half represent experiences with young children or teenagers. A bibliography of program resources is also included.

THE ROLE OF THE FAMILY PHYSICIAN IN AMERICA'S DEVELOPING MEDICAL CARE PROGRAM: a report and commentary. James E. Bryan. Warren H. Green, Inc., St. Louis, Mo. 1968. 57 pp. $2.

The new family physician should be trained to "comprehend the health needs of a whole person, be the captain of the medical team, and command all the instrumentalities available to meet those needs," says the author of this book, which is based on conferences sponsored by the Family Health Foundation of America in 1965, 1966, and 1967. Emphasis is placed on the need of every person for a personal physician who can integrate all medical and related services and insure continuity of care.

Among other topics, the author discusses the vanishing general practitioner, the family physician as a functional specialist, medicine and the hospital, and university and graduate medical education.

FACES OF THE ADOLESCENT GIRL. Lillian Cohen Kovar. Prentice-Hall, Inc., Englewood Cliffs, N.J. 1968. 178 pp. $4.95.

This book describes behavior patterns of five types of adolescent girls—the peer-oriented, the adult-oriented, the delinquent, the anarchic bohemian, and the autonomous—and the paths they follow in the process of becoming women. The author, a sociologist with the William Alanson White Institute in New York, observed 79 high school age girls in three mental hospitals in New York City and a control group of 72 suburban and city girls. The autonomous girl who can think and feel for herself is the model adolescent, Dr. Kovar says; it is her thesis that only the autonomous girl is mentally healthy.

THE COMMUNITY'S CHILDREN: long-term substitute care: a guide for the intelligent layman. Edited by Jessie Parfit. National Bureau for Co-operation in Child Care (England) in association with Humanities Press, 303 Park Ave. South, New York, N.Y. 10010. 1968. 108 pp. $2.75.

Information about the kinds of child care available in Britain outside of the child's own home is presented in this book, which was prepared at the request of the Association of Child Psychology and Psychiatry by a working party of 11 professional people. It discusses attitudes on child care of parents, children, residential staff members, child care officers, and foster parents; special needs of "lost and failing" children; services and training available for child care workers; and the future of child care. The editor concludes, "The establishment of an integrated child care and family service, which gives casework support to children and parents both when they are together at home and when they are separated, is essential."

# READERS' EXCHANGE

**GROB AND VanDOREN: *Satisfaction and regret***

In their article, "Aggressive Group Work With Teenage Delinquent Boys" (CHILDREN, May–June 1969), Grob and VanDoren show extremely well how two social group workers were able to convey their sense of respect and caring to institutionalized delinquent boys by *working with them* and by letting them *experience* cooperation, ways of getting along with others, problem-solving (how does one remove a tree stump?), and creativity through trying out their own ideas in the use of tools. The youngsters also *experienced* the need for setting limits on their own behavior—not because of some adult edict—but because of the danger involved in handling tools or working in extremely hot weather.

It is refreshing to read of social workers literally "getting their hands dirty" by participating in the activities they expect of the young people with whom they work. Group workers have been ridiculed, considered "unprofessional," and frequently rejected by others in their own profession because they did not exclusively adhere to the "verbal model" created by casework.

At present, we hear an outcry for genuine respect from groups of people in our society that feel demeaned and misunderstood by many professionals. This should help to convince social work that it has long had gold in its backyard in the form of group work, an approach to human problems based on concepts that such people demand: participation in decisionmaking; *experiencing*, not only talking, about human relations; understanding of nonverbal communication; and emphasis on mutual aid. In describing such group work concepts and principles in practice, the article by Grob and VanDoren arouses in this reader satisfaction, hope, but also regret—regret that it is still necessary in the correctional field to prove that one must treat people like human beings.

It is tragic that harrassment and ridicule still are being used in work with young people. It is also tragic that institutions are still run on the premise that youngsters will become better members of society when they are made to conform and are not involved in any decisionmaking. Social workers often maintain that they are in the forefront of social reform. Yet, in the institutions where they are almost "kings," they have frequently been unable or unwilling to realize the most basic principles of human dignity. There *are* institutions, of course, that have used those principles. Yet, in the late 20th century, there should be *none* where one still must demonstrate that being treated with respect is essential to help our young delinquents. One can only ask with despair, "If not now, when?"

**Gisela Konopka**
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**HUGHES: *A child welfare service***

In her article, "Services to Children Living With Relatives or Guardians," Shirley L. Hughes provides a convincing example of the need for child welfare services by children in the public assistance caseload. (CHILDREN, May-June 1969.) She describes how, under stimulus of the 1962 amendments to the Social Security Act, the Baltimore County Department of Social Services has been providing special attention to children in the AFDC program who are living away from their parents with relatives or legal guardians.

The article is of value also because of its description of some of the requirements for providing casework service effectively: caseload size related to function and method; recognition of the advantages of specialization of tasks for better quality and accountability; the importance of a thorough preliminary study; intensive activity to meet immediate needs and to establish a relationship with the client.

What Miss Hughes has described seems to be the development of a child welfare service within the public assistance division in her agency. If this is true, it raises questions of the organization and availability of child welfare services elsewhere in the agency or in the community and the concepts that govern those services.

The apparent practice of the court in Baltimore County of relying on relatives and other persons as guardians or parent surrogates, would seem to indicate a failure by child welfare agencies to offer sufficient, or sufficiently broad based, services to the court to meet the needs of children coming before it. True, in many of our communities foster care, when needed, is not easily available either to courts or to parents by their own direct application, yet the problems described in Miss Hughes' article are those that can often be prevented with timely counseling to parents coupled, when necessary, with foster care.

My comments on service organization should not obscure the sense of responsibility that the Baltimore County agency demonstrated for a group of children frequently overlooked in child welfare services, a group that exists not only among the poor. At all levels of society relatives or unrelated persons acting as parent surrogates may assume a responsibility for children reluctantly or with a mistaken understanding of its implications. Many parents, no longer able to provide a home for their children, need the help of child welfare services in making plans and decisions and understanding alternatives and their implications, and children away from their parents need continuing services.

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**HEW refers to Department of Health, Education, and Welfare; SRS, to Social and Rehabilitation Service; NIH, to National Institutes of Health.**

OPTIMAL HEALTH CARE FOR MOTHERS AND CHILDREN: a national priority. HEW, NIH, National Institute of Child Health and Human Development. NIH Publication No. 127. 1968. 92 pp. Single copies free from the Institute.

Summarizes the discussions of five interdisciplinary conferences concerned with defining the needs in program development, training, funding, administrative structure, and research required to develop comprehensive health care for families and children.

CHARACTERISTICS OF HUMAN RESOURCES IN THE RURAL SOUTHEAST COASTAL PLAIN . . . with emphasis on the poor. Jackson V. McElveen. Economic Research Service, U.S. Department of Agriculture. Agricultural Economic Report No. 155. 1969. 90 pp. $1.

Reports on a study of residents of a 10-county area of South Carolina, pointing up the high mobility of young people—particularly among nonwhites—lack of jobs, inadequate income or economic deprivation, current high rate of school dropouts, functional illiteracy among adults, desire for job training, and other problems and needs. Data are given in 59 tables.

RESEARCH RELATING TO CHILDREN: bulletin no. 23 (January-August 1968). HEW, SRS, Children's Bureau, Clearinghouse for Research in Child Life. 1969. 161 pp. $1.75.

Contains brief descriptions of current or recently completed research studies reported to the Children's Bureau between January 1 and August 31, 1968, dealing with child growth and development, special groups of children, family relations and child rearing, socioeconomic and cultural factors, educational factors and services, and social and health services.

SOCIAL SERVICES FOR CHILDREN AND FAMILIES IN YOUR STATE. HEW, SRS, Children's Bureau. CB Publication No. 464. 1969. 29 pp. 25 cents.

Describes briefly the basic elements of a Federal-State combined program of child welfare services available to families regardless of financial need and of social services to actual or potential recipients of public assistance, as provided for under the 1967 amendments to the Social Security Act. Directed to the layman who may want to participate in the development of such a program in his State.

USING VOLUNTEERS IN COURT SETTINGS: a manual for volunteer probation programs. Ivan H. Scheier and Leroy P. Goter. HEW, SRS, Office of Juvenile Delinquency and Youth Development. JD Publication No. 477. 1969. 227 pp. $1.

Offers guidelines for developing and managing programs using volunteers in probation services in juvenile courts. Discusses among other subjects recruitment, screening, selection, training, and orientation of volunteers; instillment of volunteer incentive and support; and program assessment.

HEMOLYTIC DISEASE OF THE FETUS AND NEWBORN DUE TO RH ISOIMMUNIZATION. Jane S. Lin-Fu. HEW, SRS, Children's Bureau. 1969. 15 pp. Single copies free from the Bureau.

A technical paper that traces the history of Rh hemolytic disease of the fetus and newborn from discovery of the Rh factor to the recent development of preventive measures. Incidence, pathogenesis, mortality and morbidity, treatment, and prevention of the disease with the use of Rh immunoglobulin are discussed.

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